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ABSTRACT

Suicide and attempted suicide are problems which continue to occupy the world-wide attention of both health service administrators and research workers. National statistics of completed suicides have shown an increase in rates among people aged 15-24 years and even among children below the age of 15. Conference discussions were based on working papers relevant to four main WHO categories: community mental health services; mental health of children and young people; alcoholism and drug dependence; professional education and training. The topics specifically included are: (1) Modern Trends; (2) Psychopathology; (3) Social and Cultural Aspects; (4) Risk Factors; (5) Prevention and Intervention; (6) Suicide Prevention Services (and their evaluation); (7) Information Systems; (8) Research; and (9) Training and Education of Suicide Prevention Workers. (BN)

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Suicide and Attempted Suicide in Young People

Report on a Conference

Luxembourg
19-23 August 1974

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Note

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The views expressed are those of the participants in the Conference and do not necessarily represent the decisions or the stated policy of the World Health Organization.

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This report is also available in French and Russian.

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1. Introduction

Suicide and attempted suicide are problems which continue to occupy the attention of both health service administrators and research workers. It is noteworthy that crude suicide rates remain remarkably stable or show only slight increases or decreases over long periods of time, whereas suicide rates in subgroups (sex, age, occupation, social class) are subject to much wider fluctuations. National statistics of completed suicide have recently shown an increase in rates among young people aged 15-24 years, and even among children below the age of 15 years. National statistics of suicide attempts are difficult to obtain, but research reports suggest that here also there is an increase among young people.

Problems of mental health must be looked at in the general framework of public health problems. As such, they are the subject of legal measures as well as health educational ones. To carry out these functions successfully those concerned must be provided with the fullest possible information, since it is not enough for something to be done; what is done must be systematically planned and carried out. With such objectives in mind, the WHO Regional Office for Europe called together a Working Group, which met in Zagreb, Yugoslavia, from 1 to 4 October 1973, to examine the present state of suicide studies and to plan future work in this field which might include studies of the regional variations in rates of suicide and attempted suicide, the different forms of intervention after a suicide attempt, various forms of self-destructive behaviour and the length of time needed for deciding that a person who had made one attempt would not make another. The report of this Working Group can be found in WHO Public Health Papers, No. 58,[1] and it will be noticed that as part of the preparation for the Conference now reported members of the Working Group agreed to undertake a study of attempted suicide, the results of which are included in this report in Annex VIII.

The Conference on Suicide and Attempted Suicide in Young People was held in Luxembourg from 19 to 23 August 1974; the agenda is attached as Annex IX. The Conference was opened by Mr E. Krieps, Minister of Public Health, who welcomed the delegates. He said they would be discussing a subject of great importance to his country as to others, at the present time. Mr J.U. Hannibal, Technical Officer in the Mental Health unit of the WHO Regional Office for Europe, read a message from the Director, Dr Leo A. Kaprio, thanking the Luxembourg authorities for their hospitality and wishing the members of the Conference success in their work.

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[1] World Health Organization (1974) Suicide and attempted suicide, Part II, Geneva (Public Health Papers, No. 58)

Dr R. Sadoun, France, was appointed Chairman, Miss E.M. Brooke, Switzerland, Rapporteur and Mr J. Hannibal, Secretary. The list of participants is attached as Annex X.

Suicide and attempted suicide are problems of particular interest in the long-term programme in mental health of the WHO Regional Office for Europe since they relate to each of the four main divisions of this programme, namely:

(1) community mental health services;

(2) mental health of children and young people;

(3) alcoholism and drug dependence;

(4) professional education and training.

1.1 Method of work

The discussions of the Conference were based on a series of working papers which had been prepared and distributed to participants in advance of the meeting. The working papers are attached to this report as Annexes I - VIII. The participants were divided into four working groups according to language, which met separately to discuss questions which arose out of the working papers. These discussions were interspersed with reports to the whole conference and discussions in plenary session. On the fourth day the results of the Pilot Study of Attempted Suicides which had been carried out by centres in several participating countries were presented and discussed. The last day was devoted to the subject of education and training, in the course of which a film on the work of European suicide prevention organizations was shown.

2. Modern trends in self-destructive behaviour (Annex I)

It is customary nowadays to include under self-destructive behaviour not only suicide and attempted suicide, abuse of medicaments intended primarily for therapeutic purposes, drug addiction, alcohol dependence, and excessive smoking, but also traffic accidents, especially those due to drunken driving. Modern warfare could also be seen as a form of mass self-destruction.

Statistics do not reveal the full extent and nature of the problem of self-destruction. They may, for example, assign deaths from drugs or alcohol to septicaemia or hepatic cirrhosis. Although some 10 000 persons die every year in France from alcoholic cirrhosis of the liver, the mass media tend to concentrate on the relatively low number of deaths from drug addiction. Deaths due to overdose can be equally well explained by the addict's tendency to depression, his neglect or refusal of personal care, or his habit of taking self-prescribed psychotropic drugs.

Furthermore, statistics cannot take into account the psychological motivations of those who make suicide attempts.

Self-destruction is a phenomenon which can be individual or collective, and also conscious or unconscious. The anxiety produced by the breaking up of social groups can involve a demand for oral gratification, an awakening of the death urge and a reinforcement of depression which might be complicated if an external factor intervenes, by the passage to a suicidal act, whether consciously or unconsciously motivated. At all levels the self-destructive process is influenced by difficulties of interpersonal communication. The stimulation provided by the mass media by exaggerating all violent phenomena, may tend to encourage acts of violence turned against the self.

For the security of his personal development, a young person requires a stable model with which he can identify, but sometimes he cannot find it, the parents often being in grave difficulties themselves. It is sometimes thought that whatever motives may exist, whatever the victim's personality type, it is the environment which kills the person with suicidal tendencies, for, as Durkeim has said, "the suicide rate depends on the extent to which an individual is integrated into society". Factors favouring suicide among young people in developing countries, where 25 or even 10 years ago suicide was unknown, include leaving the ancestral group after a traditional education and preparation for adult life and being plunged into the "anomia" of newly industrialized regions, without the possibility of progressive adaptation.

Classical forms of mental disorder are less often found among potential suicides than might have been expected. However, suicide attempts may usher in psychosis, hence one must make sure not to treat them too lightly. In any case, to choose a suicide attempt as the gateway to a psychotic anxiety state may be one of the best ways of appealing for help. A study has been reported where only 30% of failed suicides were receiving adequate drug treatment for depression. At the same time the frequent depressive syndromes which are found among the young may provide open doors to suicide if they are neglected or poorly understood. In the face of self-destructive behaviour, effective means of reanimation have been developed, but the treatment of those who have attempted suicide and especially the prevention of subsequent attempts is not well understood.

Several questions arose out of this presentation:

(1) Depression in young people: what forms did it take today; how frequent was it; how is it related to forms of adult depression?

(2) Suicide equivalents and unconscious suicidal behaviour: how do these relate to alcohol- and drug-dependence among young people?

(3) Does the break-up of groups and of families linked with the more or less rapid changes in modern society produce a society which is "suicidogenic"?

It was felt by some participants that not all forms of self-destructive behaviour should be regarded as suicidal, as this made the group too broad. None of the forms of behaviour described as self-destructive were necessarily seen in this light by young people, who did not realize the irreversibility of suicide or appreciate that drug-taking and alcoholism were self-destructive. To many people, alcohol added to the enjoyment of life. Juvenile delinquency might also be an appeal for removal from an intolerable situation but the use of such subjective ideas as the "unbearable nature of life" should be treated with caution.

It is essential that all terms used should be clearly defined, whether suicide, attempted suicide or parasuicide. It should be clearly stated, for example, whether deaths were intentional or consequential, whether or not the methods used were serious, the action a conscious one and the result fatal. Completed suicides will include not only those whose intention was to die, but those who did not mean to, but were not discovered in time to be resuscitated, while attempted suicides are likely to include some people who intended to die but were found in time to be prevented.

Many suicidal persons are suffering from a depression. In young people, it was suggested, the signs of depression include feelings of emptiness, hopelessness and gloom. They complain of boredom, see no future, have no ambition and poor powers of concentration. The illness frequently responds to antidepressive drugs, and if there is already a case of depression in the family, it is likely to respond to the same drugs as those already being used. Teachers, parents and general practitioners can learn to watch for and treat these symptoms. Depression may act as a psychic infection among young people. The general consensus of opinion, however, was that there is no convincing evidence of a depressive syndrome which is specific to young people, although depressive traits may appear to be more frequent in certain individuals or social groups.

While the break-up of the traditional family group may be suicidogenic in developing countries, it must be remembered that in western society the concept of childhood has only appeared in the last 100 years. Without the grandparents' stabilising influence, parents may be very unsure how to handle their children and may need support. Some young adults may then be better away from their families, in hostels for example, where having a room of their own will give them a sense of personal identity. This will be especially true where family members or close friends have made suicidal attempts, since the correlation is four times higher than in the general population. Nevertheless, there was general agreement that the break-up of the family unit had an increasing effect on the risk of young persons committing or attempting suicide.

3. Psychopathology of suicide and attempted suicide (Annex II)

Attempted suicides may be ten times as frequent as those carried out, but vary in the intensity of the intention to die. While some people are determined to end their lives and succeed in doing so, and others may wish to die but fail for various reasons, such as not taking a sufficiently large dose of poison, or being found in time; others merely want to ensure a long sleep which will blot out their past troubles, so that when they wake they can make a fresh start and also obtain some help in overcoming their difficulties.

The progress of the suicide plan is of special predictive importance, because it is a way of turning fantasy into action. Thoughts of suicide may help to give temporary relief from the tensions caused by distressing crises. The suicide plan contains other psychic elements and is strengthened by repetition within the imagination and by threatening to kill oneself. At first the plan appears dangerous and causes anxiety, but later it attains an indepedent structure within the ego. Various preliminary steps are taken such as buying a gun and practising the act of shooting oneself. An ongoing action has now begun which sooner or later will culminate in the actual attempt.

Suicide prevention activities benefit if it is realized that suicidal plans occur in persons of defective ego-structure, with a low potential tolerance for stressful situations, resulting in anxiety and depression. Such persons have a destructive trait in the super-ego, either inborn or related to childhood circumstances. A person thinking of suicide often feels unloved, a sentiment increased by loneliness and isolation. By dying through suicide he hopes to get that love and sympathy which have been denied him; especially among the young, he does not realize that his act is irreversible. His strategy may succeed at first, but will not survive repeated attempts.

Death may be libidinalized; a person may strive to regain contact with a deceased loved one by dying himself. Suicide is also likely to occur where dependent character traits contribute to the development of a weak identity, which results in panic if a separation from the object of dependence occurs. Other persons at risk are those whose way of life contributes to self destruction by alcoholism, use of narcotics, or smoking after myocardial infarction. In alcoholics the risk of suicide has been estimated to be approximately sixty times as great as that of the total male population of the same age. Among psychiatric patients, those who subsequently commit suicide tend to be more gravely disturbed, to have more severe symptoms and to be more prone to acting-out behaviour. They are demanding in treatment, while provoking conflicts and rejection in therapeutic relationships.

Particular attention should be paid to those young people who were children when their parents or close relatives died, especially if they committed suicide as this establishes a behaviour pattern which can be

resorted to in times of crises. Those who attempt suicide may have aggressive feelings towards those around them that in turn cause guilt feelings, and these guilt feelings lead to the aggression being directed towards themselves.

Discussion on the similarities and differences in psychopathology showed that it would be useful to distinguish more clearly, according to their psychopathology, between the subgroups of suicide attempters referred to above (for example, those who intend to die, those who die by misadventure, and those with psychopathological deficiencies), as such distinctions might prove to have predictive value. It was said that in Sweden 80% of suicide attempts in young people were made by girls, despite the fact that males are generally regarded as being more aggressive. However, some recent figures indicated that this trend had now changed and more boys were making suicide attempts.

In France a study of the family background of young suicide attempters and a control group of schoolchildren who were not attempters, using psychological test techniques, showed the suicide attempting group to be much more disturbed with a higher percentage of dramatic, histrionic response, greater frequency of depression and psychopathy. Overall, only 9% were regarded as being normal. From Bulgaria, as elsewhere, came reports of some flamboyant suicide attempts in young people, such as by setting fire to themselves in school playgrounds or at birthday anniversaries. In the Netherlands attempts had been made to distinguish between groups of attempters and committers by such indicators as whether there were other people present at the time.

4. Social and cultural aspects of suicide and attempted suicide in young people (Annex III)

Suicide ranks second or third as a cause of death at ages 15 to 24 in many European countries. The rate of attempted suicide is increasing rapidly in this age-group, as are other types of self-destructive behaviour including drug dependence, which many regard as a slow form of suicide, and alcohol abuse including drunken driving. These statistical trends cannot be attributed to any one feature of society or psychological development, since they ignore intra-personal struggles. In such cases suicide can therefore only be examined as a social and psychological phenomenon, and as one occurring in a defined cultural setting, since an individual's attitude to suicide as a solution to personal conflict will correspond to that in his culture. One way in which society affects an individual's proneness to suicide is through its attitude to suicide itself, considered not only as a personal phenomenon but also (e.g., during wartime) as a social one.

In traditional society the family is the centre, with other institutions, educational, religious, political and economic, which are kept in balance as long as they are separate entities. The balance is upset if one institution penetrates another, as is happening now, when economic and political

institutions are penetrating the family thereby reducing it to a mere consumer unit. The observed lessening of family stability has a marked effect on young people during their period of physical and social maturation. Technical development which nevertheless demands a high and differentiated standard of education has encouraged many to aspire to levels which only a few can reach. Adolescence seems a harder and longer period than before, and for many can only lead to frustration, creating a highly vulnerable group. Hence the young reject the prevailing value system but have nothing firm to put in its place. The ones most affected form marginal groups which are potential reservoirs of alcohol- and drug-dependence, delinquency, absenteeism, sexually transmitted disease, suicide and attempted suicide.

Just as the discussion of psychopathology led to the question of whether subgroups of suicide attempters with varying degrees of determination to die could be distinguished by their psychopathological characteristics, so the present discussion led to the question of whether it was or was not possible to distinguish, by their social characteristics, those groups who commit or attempt actual suicide, from those showing other forms of self-destructive behaviour, such as drug dependence or alcoholism.

It was felt that the answer to a question like this would need to be based on work which had already been carried out. According to reliable studies of this kind, the answer would be that it is possible to make these distinctions. But social factors as observable facts are subject to misinterpretation. The questions asked may not be the right ones, and in that case the answers will be misleading.

There was also some disagreement among members of the Conference about the right to call drug dependency and alcoholism self-destructive behaviour, as they appear to some people to be behavioural patterns which have self-damaging effects but which do not necessarily carry with them a conscious intention of self-destruction. Suicide and attempted suicide on the one hand and alcohol and drug addiction on the other are phenomenologically very different types of behaviour, and there are dangers in always presuming self-destructive intentions in alcoholics and drug addicts. At the same time, it was true that all these forms of behaviour were forms of reactions to stress, and if stress was the common denominator, then perhaps a genetic factor or learning experience might determine in any particular individual whether the response was attempted suicide or addiction or some other form of deviancy. Under those circumstances the relationship between delinquency or addiction and suicide or attempted suicide would be only partially relevant to the overall suicide problem. It was emphasized that because two different types of behaviour (such as attempted suicide and drug addiction) occur in the same individual, the link between them cannot be assumed to be causal, nor can it be presumed that they have a common origin.

5. Prevention, intervention and subsequent action ("postvention") in suicidal behaviour (Annex IV)

Attempts have been made to fit suicidal behaviour into a "disease model", implying that thoughts of suicide, announcing intent, attempting and finally committing suicide are all increasingly severe phases of the same "suicide disease". The notions of primary, secondary and tertiary prevention could then be applied to such a "disease". Helping agencies have therefore tried to concentrate on those who, according to this model, would be likely to commit fatal suicide, namely those who make an attempt. Help can, however, only be given when tendencies manifest themselves in overt behaviour, of which the three forms are communication of intention, suicidal attempts and suicide. Epidemiological and follow-up evidence suggests that these three phenomena are distinct and independent events and not interrelated within the so-called "suicide disease" and that each requires different forms of help.

While suicidal attempts may be a means of directing other people's attention to the victim's urgent need for help, they are only of use if there is a definite chance of his getting assistance, and this in turn depends on the degree of integration of the attempters into society. Hence, completed suicide is frequent among old people, who are often completely isolated, while attempted suicide is more common in younger people who have not yet achieved their adult identification. If helping action is to be directed towards suddenly occurring phenomena, the concepts of prevention, intervention and postvention are more useful than those of primary, secondary and tertiary prevention, because they simply categorize helping activities according to the time of presentation of the pathological phenomena. Prevention involves taking all possible steps before the phenomenon occurs, so as to prevent its coming into existence, intervention consists of the activities to be undertaken during its occurrence, and postvention everything carried out after the phenomenon has taken place.

In order to bring the services into operation it is necessary to know where to look for those likely to need them, that is, to identify high-risk groups. A multidimensional approach has been used in Vienna to find groups with varying degrees of risk. Using eight variables (age, sex, retired or not, first or repeated attempt, conflict or unhappiness motive, poisoning or hard methods, ingestion or not of alcohol before the attempt and conscious or not at admission) a cluster analysis was carried out for 276 patients admitted to an intervention centre after attempting suicide. Seven clusters were formed, in two of which 48.5% and 23.5% respectively were dead at two years later, though not necessarily by suicide. Such cluster analysis indicates the characteristics of vulnerable groups requiring special prevention and postvention services.

Two important questions which arose in relation to the concepts established in Vienna were firstly how to find possible high-risk groups in the prevention period, and secondly what kind of services should be set up (with what kinds of personnel) to deal with the periods of intervention and postvention. So far as the first question was concerned, it had

already been established that depressive patients, alcoholics and members of their families, and old people were among the groups at high risk. In particular old people should be known about, registered, cared for and visited, and should be contacted by telephone. They should be told by letter or by the mass media what to do in times of difficulty and how and where help could be found. The setting up of comprehensive mental care services to cope with all the factors involved in suicide problems - alcoholism, marriage difficulties, juvenile delinquency - was agreed to be essential.

Another positive step towards suicide prevention lay in the restriction of prescribing. Medicaments, especially those such as barbiturates which might be used as suicidal agents, should be sparingly prescribed. When needed, physicians should find out whether the drugs prescribed had been consumed. They should also try to find out if other colleagues had prescribed similar drugs, to the patient himself or to family members. Suicide being often an impulsive act, it was necessary to prevent the accumulation of a stock of possible agents, as unless the means were to hand, the impulse might pass and the sufferer seek to obtain help in some other way.

In the detection of high-risk groups, multidimensional research was needed. This should concern psychiatrists, because of their clinical skills, psychologists in attempts to determine those conflicts and motives giving rise to suicidal behaviour, and sociologists and statisticians in detecting groups and areas which seemed suicidogenic; for example, attempted suicide seemed to have high rates in over-populated areas.

As regards services, it was felt to be important that general policy should be planned, and research controlled and developed. There should be homogeneity, and coordination of the specialized services.

So far as intervention is concerned, there can be no single institution really suitable for providing all services. Intervention is only one stage in a process which has to be made more effective. However, a programme must be developed which can perhaps only be implemented when a more understanding attitude towards suicide has been brought about in the general population.

Suicide services may best be integrated into general comprehensive mental health services. A psychiatrist should be available in all intervention centres, but may not have the necessary skills for resuscitation. If specialist resuscitation care is not available, general practitioners may be reluctant to refer patients, while if there is no psychiatrist available the patient may get sent straight to the mental hospital. A drawback of intervention centres independent of a general service is that they may not be able to keep the patient long enough to carry out long-term therapy, so that there would be discontinuity of care. Psychiatric care is essential for other members of the family after one member has made a suicidal

attempt, because of the psychiatric infection of suicide among the guilt-ridden and depressed people left behind. At the same time it must be realized that a resuscitation centre is equipped to cope with other emergencies than suicide attempts.

Whatever kind of worker or service is to tackle the problem of suicide attempts, there should be a concrete plan for managing the situation, and a pyramid of expertise headed by a psychiatrist. Nonprofessional workers are acceptable and appreciated but they must be selected and given thorough instruction, a practical introduction to their work and constant professional backing up. For those in positions of responsibility, very good intensive training is necessary. Hence, lay people can best be used in prevention and postvention, whereas highly trained professionals are needed for intervention.

6. Suicide prevention services and their evaluation (Annex V)

Prevention services need evaluation and into this category falls (in Britain), the Samaritans, a private national network of some 150 telephone prevention centres, offering an advertised 24-hours completely confidential service to the distressed suicidal. It is known that many clients, especially among the young, prefer to appeal to the Samaritans because they are suspicious of doctors and other established professionals. In addition to the regular branches, there are satellite befriending groups and suboffices in smaller towns, so that the great majority of people are within a few miles of Samaritan help.

Evaluation was attempted by comparing the course of suicide rates in 15 large towns before and after the opening of early Samaritan branches, with those in a control group of 15 towns matched for an extensive range of demographic and social characteristics. The average rates for the years when the service was operating were compared with those for the same number of years before the Samaritans started, and showed a drop in these towns compared with a significant rise in the other towns. Comparison with a second set of controls produced similar results.

However, in California, despite suicide prevention centres of undoubted excellence, the suicide rate rose during 1960-70, especially at ages 15-24 years and also among the black population. But a number of reasons may be adduced to account for this, including the fact that one-third used the more lethal means, firearms and explosives, whereas the British custom of taking an overdose may give a second chance.

So far as the young are concerned, general suicide rates at 15-24 years rose steadily after World War II, but stabilized in the mid 1960s and now show a slight downward trend. This age-group is represented among Samaritan clients in a proportion roughly equal to that in the population. The sexes are fairly evenly divided. In 1972, 980 clients under 14 made contact; perhaps as a result of a series of TV programmes.

University students are a particularly vulnerable group and may be best served by a "Nightline Service" operating on internal telephone lines and manned by trained students; a service by youth, for youth. The value of such a service was also confirmed by the Norwegian experience with the "Utegruppe", a field service in Oslo and three other towns. Adolescents, such as students or young workers, are selected and trained by advisers to the local town council. They are unpaid but supervised, meeting at their centre twice weekly. Their task is to meet other vulnerable adolescents in bars, discotheques, etc., in peer-group helping relationships. They have strong loyalty to fellow adolescents and only the most serious incidents are officially reported.

While such helping agencies are concerned to identify and contact high-risk groups, it was found in both the USA and the United Kingdom that young people respond better to sensational TV programmes than to newspaper reports. "Gatekeepers" such as barmen, police, etc., who are trained to recognize the suicidal and secure referral to prevention centres, are also useful. This led to some discussion as to whether a third-party referral without the client's consent should be allowed and here opinion was divided, some taking the view that anything possible should be done to save life.

7. Some research aspects of suicide and attempted suicide (parasuicide) with special reference to young people (Annex VI)

Research is clearly needed into self-aggressive behaviour in all its aspects, particularly to explain, if possible, certain phenomena. For example, in England and Wales deaths from carbon monoxide poisoning have decreased since 1962, and in the older age-groups this decrease has not been "compensated for" by a rise due to other methods, whereas at ages 15-24 years there has been a rise in noncarbon monoxide deaths for both sexes. However, when Holland changed over from toxic to nontoxic gas in the 1960s, the method of suicide changed from gas to other forms of poisoning. Some attribute the decrease in carbon monoxide poisoning deaths among British youth to their not being gas-minded like their elders, and others to better intervention and resuscitation services.

It is perhaps important to make an operational distinction between completed suicide on the one hand and nonfatal self-aggressive behaviour on the other. For the suicide attempt three kinds of rates may be used; the admission rate, or number of events per unit of the population at risk; the person rate, in which any person will be counted only once in a given year even if he makes more than one attempt, and the "first-ever" rate, measuring the number of first nonfatal self-aggressive episodes known. In the last six years in Edinburgh (Scotland) for women aged 20-24 years the admission rate doubled, the increase in the person rate was less striking and the "first-ever" rate showed only a modest rise. Increase in the attempted suicide rate therefore reflected an increased liability to make further attempts, once a first one had been made. The questions posed here are why the first attempt was made and what factors made

people willing to repeat it, especially as the solution is only temporary and resuscitation may be a very unpleasant experience.

The prediction of repetition is a logical priority, but the interpersonal crises in which it appears are mostly unpredictable. In any case, mainly for statistical reasons, the application of such findings as are possible is likely to have rather limited practical results. Moreover, research studies should employ suitable sampling techniques so as to be comparable, and should include both urban and rural areas, where rates may be quite different. Both suicide and attempted suicide have more than one reason and in each case there may be distinguished disposition, objective reason, subjective psychic reason and a trigger factor.

8. The role of WHO

WHO Public Health Paper No. 58,[1] examined methods of ascertainment in 24 countries and showed that the fact of the enquiry being so often a legal process appears to be the only uniform factor. A case history exercise carried out by 21 assessors in 9 countries on 20 cases each from Denmark and England and Wales, was designed to find out the extent to which there would be agreement on verdicts made by doctors or legal persons when presented with the same evidence. Here again there was wide variations between those assigning cases to suicide, accidental death, open verdict or natural causes. This suggests that caution is needed in comparing suicide rates between countries.

The discussion revealed the need for WHO to develop a common terminology for suicide studies, in the same way as a common diagnostic system is used. With regard to national statistics, it was always probable that many deaths were not registered and slightly more not certified. The doctor's subjective desire not to hurt relatives could result in grave understatements. Hence it is better to examine trends within a country, rather than between countries.

It was suggested that WHO could assist the progress of the fight against suicide in several ways, such as providing national administrations and institutions with information and basic data, by developing training programmes for those working in suicide prevention, by nominating recognized suicide experts and by encouraging agencies and governments to undertake research into all aspects of self-aggressive behaviour. Support could also be provided by initiating conferences and by promoting prevention centres.

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[1] World Health Organization (1974) Suicide and attempted suicide, Geneva (Public Health Papers, No. 58)

9. The pilot study on attempted suicides (Annex VIII)

The Working Group which met in Zagreb in 1973 to prepare the present Conference had proposed that an enquiry be made into attempted suicides in which the countries represented would participate. A simple data collection sheet was designed, which it was agreed would be used, containing both medical and sociological information on patients, and a description of the services. The study aimed at finding out whether the data could be collected and whether in the light of this experience, some questions should be altered, removed or exchanged for others.

The results showed that information which could be got from case records was fairly complete but much more effort was needed with regard to other questions, such as whether alcohol or drugs had been ingested before the attempt and whether or not the patient was visited by a "significant other"; in the latter case the numbers of "not known" vitiated the replies. The importance of background information was emphasized, for example unemployment among the patients should be set against how much unemployment there was in the country and why; similarly the types of patients and treatment received had to be set against the description of the services and their staffing.

The results of the enquiry are shown in Annex VIII.

10. Education and training

The final session of the Conference was devoted to education and training. It was felt that the first essential is to let the community know what suicide prevention is really about, since they are the first people to be responsible. This may be done by posters, radio and television programmes, articles in journals, and talks to groups of people like schoolchildren, women's clubs, etc. A useful way to bridge the generation gap is to have groups of adolescents from one or two schools discussing problems, not with their own parents, but with those of other young people.

For recruiting workers in suicide prevention it is useful to find someone who has a personal knowledge of the candidate, as well as using screening techniques. In Belgium for instance, legal standards are laid down for the selection, training and professional backing-up of volunteers. Research might show what is the motivation of the successful suicide prevention worker and whether persons with a suicidal attempt or suicide in the family are acceptable. For telephone services it is most important that the respondent listens in a noncensorious way.

Groups who have stated a need for training for the suicide prevention services include ministers of religion, social workers, nurses and psychiatrists. Methods of training may include tapes, films and role-playing. For example, a recruit may be able to "listen in" to another at the telephone talking to a client. Groups of workers may meet to discuss the taped activities of the workers, although here some doubt was

expressed about the desirability of using a taped conversation, even for training. On the question of third-party referral, it was pointed out that of those contacting the Samaritans in Britain, one-third to a half call about someone else. If a third party refuses permission to have contact made for him, some organizations do it anyway, feeling that they are a Suicide Prevention Service. Nevertheless, it is important to avoid putting a label of psychiatric patient on all who attempt suicide, although there are undoubtedly cases with psychiatric illness among them. Perhaps what is needed is a combined service, dealing with all the disturbances of adolescence and not breaking them up into suicide, drug taking, baby battering and other groups. The unhappiness shown in attempted suicide is only the tip of an iceberg of unhappiness in families.

ANNEX I

MODERN ASPECTS OF, AND TRENDS IN, SELF-DESTRUCTIVE BEHAVIOUR

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The problem of self-destruction takes various forms. Suicide or attempted suicide is the clearest example. However, numerous equivalents of suicide exist, fostered by modern living conditions, such as the abuse of drugs intended for medical purposes, drug addiction and pharmacodependence, together with certain forms of traffic accidents and, of course, alcoholism. Some people would add to this list a series of hetero-destructive behaviour, individual and collective, types of violence ending in the social or moral destruction of the individual by himself, such as wars and their fatal suppressions.

An attempt can be made to analyse these various types of behaviour point by point. One can, for example, start from parasuicides of medicinal origin and end with an assessment of the evolution of industrial chemistry which is transforming our society. When society, fully subject to the "chemical intoxication" of the second part of the 20th century, gives itself over to the excessive consumption of pills, it should not then cause any surprise to observe (1) the very high voluntary absorption of drugs, particularly the hypnogenic psychotropic drugs, for a suicidal purpose, and (2) the spread of the drug addiction phenomenon, the real importance of which is not yet known, although it is recognized to be one of the major problems of present-day youth.

It should be remembered that in France, 10 000 persons annually die from cirrhosis of the liver of alcoholic origin; a figure which by far exceeds the official figures for drug addiction or deaths of drug addicts. The death of the drug addict can be explained equally well by his cyclical depressive tendency, his habitual carelessness, his neglect of bodily care or his refusal of treatment, or his habit of taking psychotropic drugs for self-treatment purposes.

As for traffic accidents, American statistics have shown that mechanical failure is the cause in less than 15% of the cases (4% in France).

Thus, it will be appropriate to approach the general problem of modern self-destructive conduct as a function of conscious and unconscious motivations, but also in accordance with the intentional or sub-intentional nature of the death. This will make it possible to distinguish what is accidental and what is not, what is intentional and what is not.

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Cases of violence present themselves as the aggressive face of a phenomenon in which the aggressiveness is repressed with no possibility of passing over into action other than by committing aggression against oneself and destroying oneself.

The approach to, or study of, these types of modern conduct should also be envisaged from a socio-analytical point of view.

In outline, one can therefore postulate that, starting from an undeniable fact, the individual (and particularly the young person) encounters problems of adaptation or readaptation. The behavioural trend proceeds towards certain types of liberation (political or sexual, amongst others). But, for the question which interests us (self-destruction), it is possible to distinguish between on the one hand an individual and collective form, and on the other hand a conscious and unconscious form. But, whatever form is being considered, it must be admitted that society, and the adaptation of the individual to society, will condition the type of self-destruction. This is where the media, industrialization and mechanization, become the factors intervening in the genesis of the collective anxiety and in its major complication, depression. For, in fact, everything depends on determining the modern depressive factors, given the present high frequency of exogenous depressions. The anxiety produced by the breaking up of social groups can lead to a demand for oral gratification, and awakening of the death urge, and thence a reinforcement of the depression, complicated (if an external factor intervene) by the passage to a suicidal act, whether conscious or unconscious, anonymous or not, like a traffic accident, for example.

It seems in any case clear that modern society has provided additional means for the individual to proceed to the suicidal act, i.e., to mobilize his death wish and to permit a change in the balance between his primitive instincts of Eros and Thanatos.

One of the most striking recent examples of this is the phenomenon of suicide in areas where this problem was unknown 25, or even 10, years ago; for example in Japan, where suicide, quite common in the adult, was still unknown among the young.

Precise studies have shown that in regions as different from one another as the centre of ~~Sicily~~, Lagos in Nigeria, Bangalore in India, and Singapore in South East Asia, to which can be added other African regions such as Zaire, Morocco, and all newly-industrialized regions, young people who have had a traditional education, acquired within a group homogeneous with the ancestral culture, find themselves plunged and drowned in an environment to which they have not been able to get progressively accustomed. They cannot make the passage from the African "hut" to life in huge, rented blocks of the skyscraper type with no community organization. Furthermore, we know that the breakup of a group produces a collective anxiety, which may lead to serious mental complications through the moral and sociocultural rupture which it provokes.

Furthermore, we know that what counts most in adolescence is identification with a stable model. The adolescent is in a state of perpetual search for this identification and it is possible that the image which the young person of today has of himself is disturbed by these difficulties in finding this stable model. The difficulty comes from the fact that the things which are put before him through the sources of information which he usually receives are either poverty stricken or warlike, or else unstable, and the parental imagos are unsatisfactory. When, in addition, modern society has cut down the degree of communication between individuals, it becomes clear that the young person, floundering in the incomprehension of the adults, gains a "self" which is badly or incompletely structured. From this point onwards revolt against the father (often absent) and moroseness will be the dominant characteristic, often by turns.

Many authors have emphasized the role of the mass media. It is a fact that what is called the "catastrophism" and the "sensationalism" of the mass media exaggerates all the violent phenomena, all the wars, and all the dramas. This led UNESCO to state in one of its reports that the selection of the information is based on a desire to disturb rather than to enlighten. In a symposium on suicide and the mass media[1] in 1971, this aspect of their influence was noticed, while at the same time recognition was given to their immense power to inform, to alert the health authorities of our countries, and to fight against the taboos which still reign over our contemporary society. In fact, however, it is the dramatic force of these means of communication which affect the thinking of the young people and their unconscious. Perhaps, as some people say, they give them "ideas" or encouragement to commit suicide. Perhaps they reinforce certain myths. Mention can be made of the death of Marilyn Monroe, for example.

And what of the wars, and death in war! This is brought before us daily by a flood of radio and television and through the press. Has anyone ever measured the pulse of someone hearing the announcement of the Kippur War, or the attack on Pnom-Penh?

It can be said that whatever the motives invoked are, whatever the personality, it is the environment which kills the suicide. The individual starting from his lethal potential, may pass on to action, particularly if the social and familial context determines this. Thus we are led to the hypothesis of Durkheim, whose theory of anomia is thus proved correct and confirmed: "the suicide rate depends on the extent to which the individual is integrated into society". The lack of security felt by certain persons will incite them towards the suicidal act or towards such indirect means as drugs and violence. If it were necessary to refer to a "social ego", it would today be found inconsistent. As for the idea of death it is constantly reactivated by the phenomena described above.

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[1] Suicide et Mass Media, 1972, Editions Masson, Paris

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The epidemiological data show that the so-called classical mental disease is less often found among potential suicides than might have been expected. However, in the young a certain number of suicide attempts may usher in a psychosis. Hence the necessity to make sure not to treat a suicidal gesture in an adolescent too lightly, while not taking too "psychiatric" a view of it either. In any case, to choose a suicide attempt as the gateway to a serious psychosis is, after all, the best way of appealing for help. We demonstrated this in an intervention during the congress in Lyon in November 1973[1]. To confirm this psychopathological fact, it can be stated that a personal study on would-be suicides who were rescued, showed that only 30% had the benefit by virtue of their psychic depression, of a specific chemical treatment.

Does there exist, or are we about to be confronted with, the birth of a suicidogenic society? Readers of this text will surely think it possible. In any case, in an earlier conference, I pointed out that any theory on present-day suicide and its prevention, must remain limited and must make prevention in practice difficult, particularly owing to the excessively large number of social and political factors.[2]

Let us, however, remember that for the young person, a suicide attempt may be considered as an appeal for help, and that it is very often in his own surroundings that he finds the means for his suicide.

The self-destructive tendency may be discussed as if it were an appeal for help by the individual to the society within which he is developing, naturally taking into account the mental and individual structures.

However, on both the socio-analytical and the anthropological plane, some have thought of self-destruction as a process of natural self-selection, a tendency which is actually polyvalent. Nevertheless, the theoretical hypothesis of anomia, formulated by Durkheim, seems to be confirmed, in accordance with the modern social patterns, characterized by drugs, pills and cars. My hypotheses, following Farberow, are in line with the present evolution of the suicide problem in the United States, as seen in the young Americans, the American women and the black minorities. Is it not a fact that the Centre for the Prevention of Suicide of Los Angeles has become the Institute for the Study of Self-Destructive Behaviour?

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[1] Actualités Psychiatriques, 1974, No. 1, pp. 63-65

[2] Groupement d'Etudes et de Prévention du Suicide. 5th meeting, Strasbourg, May 1974. (To be published in Revue de Psychologie médicale, 1976)

Finally, while the present trends in self-destructive behaviour are polyvalent, we have noticed the immence frequency of depressive syndromes in young people, some serious, some less serious, but all likely to lead to attempted suicide or suicide, if they are neglected or not well understood.

ANNEX II

THE PSYCHOPATHOLOGY OF SUICIDE AND ATTEMPTED SUICIDE

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The concept of suicide is wide, covering various forms of human behaviour. The word has different meanings in different cultures, and moreover the problem of suicide and attempted suicide varies widely in its degree of severity.

It has been estimated that attempted suicides are roughly ten times as frequent as those where the outcome is fatal. In recent years there has been a tendency to consider people showing parasuicidal behavioural traits as a separate group. An example is a person who takes an overdose of sleeping pills with a definite wish to sleep but not to die. Another example is a person who takes a major dose of some drug in order to clear up marital conflicts by appealing to the spouse in this way.

The suicide plan is particularly important as a mechanism for transforming a fantasy into an act. During distressing crises suicidal thoughts provide temporary relief from tensions. The suicide plan is composed of such thoughts and many other psychic elements, such as wishes, memories, fantasies, identifications, defence mechanisms and partial adaptations. The plan is crystallized, strengthened and reinforced by repetition within the imagination, and by verbal expressions such as suicidal promises, threats and insinuations. At first the plan appears dangerous and strange to the individual himself, and it produces anxiety. Gradually, however, it attains an independent structure within the ego which is more or less distinct from the rest of the self and tolerated as ego syntonic. The individual performs various preliminary actions: for instance he chooses a gun and practises the act of shooting himself. Although the final act may be postponed for days or months, the suicide plan has acquired some of the characteristics of an incomplete or interrupted ongoing act.

When an individual fails repeatedly and relatively completely to achieve his adaptational goals, there often arises extreme uncertainty and doubt regarding the validity of his goals and the means for attaining them. At such times his identity is strongly threatened. This syndrome is particularly important for understanding the adaptational aspect of suicide, because under such conditions an individual may make desperate attempts to reduce himself to a state of nothingness. The purpose of such an action is to reach a kind of rock-bottom state from which it may be possible to learn new methods of adaptation.

It is of the utmost importance to realize that suicide may represent an attempt to find a new and better state of adaptation. This may be attained, since many societies (including those of western civilization)

are so organized that an individual who indicates that he is weak and helpless - angry with himself - puts himself into a social role which requires or at least strongly indicates that those individuals in the society who claim to be helpers or healers should take care of him and provide effective guidance on how he should live.

Loneliness, impulsiveness, anxiety, dependence on others, inward projection of aggressive feelings and self-accusations are characteristic of a depressive person harbouring suicidal thoughts. It is particularly important to pay attention to the risk of suicide in the case of elderly depressive patients. Increasing age brings with it a decrease in vitality and desire for living; human contacts grow less in number and loneliness is accentuated.

In alcoholics the risk of suicide is approximately two hundred times as high as in the total population, and the risk is still about sixty-fold in comparison with the male population of the same age. The risk of suicide is increased if the person in question comes from a broken home, whether the reason for the break is divorce or death.

Futterman (1961), Friedman (1963) and Stengel (1968) have reviewed the psychoanalytic literature on suicide, and have found that modern research workers increasingly consider that the concept "suicide" is embarrassingly wide, covering a tremendous variety of human behaviour. The emphasis has lain on the psychodynamics of human interactions which result in attempted suicides. Suicidal behaviour varies tremendously in the seriousness of the actual deed, in the degree to which the appeal for help has been communicated and in the conscious and unconscious goals of the individual.

According to psychodynamic studies, persons thinking of suicide suffer from a feeling that nobody cares for them, has ever cared or will ever care for them. This concept is compatible with sociologists' views that loneliness and isolation increase the risk of suicide. Quite often the suicide hopes by dying to get closer to a deceased relative whom he has loved, without having any ability to comprehend the unrealistic and irreversible nature of his deed. He hopes that by dying he will get that love and sympathy which he had hoped for when living, before he became disappointed in his expectations. Very often such thinking involves fantasies of relatives crying at one's funeral. When attempted suicides imply an appeal for help, the object of the attempt is often to bring about a change in the life situation which is experienced as frustrating or intolerable. Suicide and attempted suicide very often provoke guilt feelings in the relatives. On the other hand, after the attempted suicide mutual contacts do often improve, at least for a while. Nevertheless, such a development is possible only if the attitudes of the relatives and those close to the one who attempted suicide feel not only negative emotions, but also positive ones, and if the attitude of those most close to the person making the attempt is characterized by ambivalence. If the emotional attitude of the environment is solely negative, the desperate attempt brings no results. In wartime conditions only extremely few suicidal attempts occurred in

concentration camps, but many of them succeeded. It is therefore very important to emphasize the fact that even an attempted suicide which is definitely in the nature of an appeal for help still involves a high risk of suicide. The doctor should never be misled into taking a depreciatory attitude towards a patient who has attempted suicide.

If the patient's fantasies about death are characterized by warmth and loving, the risk of suicide is increased. Similarly, the risk of suicide is high if the patient's mother, father or some other close relative died when he was still a child, and even more so if they committed suicide. This sets a pattern of behaviour which can be resorted to in the face of difficulties. Dependence is often a typical feature of a patient in a suicidal emergency. The loss of some important object may give rise to an imminent risk of suicide.

It is typical of suicidal thoughts that the patient does not consider death an irreversible event. In his fantasies he may envisage his funeral and gain pleasure from the love and repentance of others which during his lifetime he had found to be unattainable. The use of narcotics by a person who is prone to suicidal ideas may lead him to complete the lethal act. Not infrequently the suicide has aggressive feelings towards those nearest to him which, owing to his guilt feelings, he eventually directs toward himself. A family quarrel is one of the most common situations releasing a suicidal attempt. Where aggressions can be worked out without simultaneously provoking guilt, the risk of suicide is diminished.

When psychiatric patients who subsequently committed suicide were compared with other psychiatric patients, it was definitely established that the suicides were more severely disturbed, their symptoms were of a more intense degree and they exhibited acting-out tendencies. As far as treatment is concerned substantial difficulties arose particularly because they presented a demanding attitude towards treatment while at the same time these patients were apt to provoke therapeutic conflicts and rejection. This kind of behaviour is in general clearly connected with the patient's previous experiences in human relationships. Such patients easily provoke anxiety and feelings of helplessness in the therapeutic team, and these phenomena further complicate the therapeutic relationship and even lead to a cessation of treatment.

So far as manic-depressive psychoses are concerned, the risk of suicide is greatest in psychotic, very deep depressions. It is also often greatest at the stage when the depression begins to show some improvement and the patient's inhibitions begin to subside.

Persistent pain may contribute to an increase in the risk of suicide, which may be committed as a paradoxical attempt to overcome the fear of death by directly attacking this impending peril. Following hysterectomy or some other operation or illness severely impairing one's self-esteem, depressive states as well as increased risk of suicide may emerge. Fear of dependence, helplessness and isolation may provoke depression and suicidal emergencies. According to Dorpat et al. (1968), in connexion

with organic diseases the risk of suicide is higher among men than women. In our culture it is more difficult for a man than a woman to adopt the role of a sick invalid, or helpless person, which however is often the outcome of many organic diseases. After an attempted suicide the prognosis is more favourable if some reactive factor, such as an unhappy love-affair, caused the attempt. If the patient has suffered from a severe and protracted somatic disease and the attempted suicide is the result of long deliberation, the prognosis seems to be poorer.

As a summary we might say that suicide is preceded by a number of recognizable features, and suicide-prevention activities are certainly helped if one is aware of them (Litman & Tabachnik, 1968):

(1) The ego-structure of a person who plans suicide is defective, with the result that his tolerance potential is low. In stressful situations such a person is more prone than others to anxiety and depression.

(2) These persons are characterized by some destructive trait in the superego. This may be inborn but perhaps more often it has something to do with the parents' undue strictness or some other deleterious circumstance in childhood.

(3) In some persons death is libidinalized. Such a person may unrealistically strive to attain contact with a deceased close relative by dying himself. Such a possibility suggests itself when conditions of living are very hard to stand.

(4) Symbiotic and dependent character traits contribute to the development of a weak identity. In cases where a separation occurs, such persons may easily get into a panic and then react by committing suicide.

(5) Some people lead a life which more or less indirectly leads to self-destruction. This may manifest itself as alcoholism, the use of narcotics, smoking after myocardial infarction or in some other forms of indirect self-destruction.

The strength of the ego is tested at the time of hard conflicts and depression, and in such situations individuals whose ego is frail may run into a suicidal emergency. Important mechanisms leading to impending suicide are, among others, loss of a loved object, exhaustion states, an upset to self-esteem, the breaking down of the defence mechanisms of the ego as a result of the use of noxious agents such as alcohol, hypnotics or narcotics, identification with a person who has committed suicide and various feelings of anxiety, rage and grief in a multitude of combinations.

Depression has been regarded as a basic reaction, just as is anxiety. It has also been considered a reaction to helplessness. When such feelings grow in strength, a young person especially may appeal for help to

those around him by attempting suicide. So far as suicide prevention is concerned, it is well to remember that those persons who earlier have attempted suicide form a definite risk group.

From the clinical standpoint, the following mechanisms associated with suicidal behaviour are common (Litman & Tabachnik, 1968):

(1) Guilt feelings demand punishment and atonement. This aspect is clearly illustrated in many letters left by suicides.

(2) A tired and suffering individual wants to sleep and escape from his hardships. This phenomenon is often associated with parasuicidal acts.

(3) The hostile feelings and thoughts of the suicide towards those around him tend to provoke guilt feelings in the survivors, since the one who committed suicide redirected his aggressions towards himself instead of towards another person.

(4) Libidinalization of death. This involves a masochistic wish to get into contact with a dead significant-other person. The father or mother who died in one's childhood, or a beloved person of later years is often an object to whom an individual planning suicide wishes to get closer.

(5) A wish to be reborn and start everything from the beginning.

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ANNEX III

SOCIAL AND CULTURAL ASPECTS OF SUICIDE AND ATTEMPTED SUICIDE IN YOUNG PEOPLE

by
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Suicide is one of the more common causes of death, now ranking in many European countries as the second or third cause of death in the 15-24 year age-group. At the same time, several reports from research workers and treatment centres indicate that the rate of attempted suicide is rapidly increasing within this age-group. Suicide and attempted suicide present serious social and public health problems. They are, however, not the only types of self-destructive behaviour observed in young people. Other problems include the increase in drug dependence, which many regard as a slow form of suicide, and the recent increase in alcohol abuse. Deaths or severe injuries from road accidents are often associated with drunken driving which shows an indifference to possible loss of life.

These trends cannot be explained by, or correlated directly with, any single feature of society or of psychological development. Social isolation, failure to adhere to social norms or achieve personal aspirations and the consequent fracture of self-esteem seem all important factors, but taken alone or even in combination they cannot tell the whole story. Purely sociological explanations ignore the intra-personal struggles caused by these environmental situations. Similarly, psychological interpretations alone fall short of a comprehensive explanation. To understand suicide fully, if we ever can, it must be viewed as a social and a psychological phenomenon. It must be studied within the context of the relevant culture, considering that culture's economic constraints, its social attitudes, its dominant character styles and their combined effect in either encouraging or precluding suicide as a solution to personal conflict.

One way in which society affects an individual's proneness to suicide is through its predominant attitude to suicide itself. The cultural influences which act throughout the socialization process play an important part in the development of personality. They form the individual's attitudes, norms and values and among these will be his attitude to death and to self-destruction. Two main threads of self-destruction can be interrelated, the first being social or institutional suicide. This is the form of self-destruction which society sometimes demands of an individual as the price of his membership. There are many examples where an individual has sacrificed himself either for patriotic reasons or to protect his family or friends, or because such a course was prescribed by social custom, e.g. the captain going down with his ship or the self-sacrifice of widows in certain societies. The other comparable cultural pattern concerns personal suicide whose motivation lies in the

preservation of personal dignity, the expiation of guilt or cowardice, the avoidance of intolerable pain and despair in disease or old age, and the unwillingness to bear the loss of love caused by rejection or bereavement.

The age-group which we are discussing has recently been the subject of many reports pointing out the inherent contradictions to which the different socialization agents, such as the family, the school and the mass media give rise. Problems also arise in connexion with the fragmentation of their activities into educational instruction, technical training, leisure activities, etc. Uncertainty occurs regarding the models for identification owing to the limited time during which certain socializing agents which were formerly of crucial importance, such as the family remain effective, and their replacement by new models like the regrouping of the young on the fringe of adult society in gangs or communal living.

One simplified way of illustrating the difference between what may be called traditional society and present-day society in most European countries, is to look at the interrelationship between their institutions. In the traditional society this interrelationship can be likened to a wheel, a unity of interdependence in structure and function. The family, which is at the centre and is the first institution the individual meets, is the hub. The spokes will then be education, religion, political and economic institutions. The rim will be the community within which the various institutions operate.

With a moderate rate of social change the balance between the institutions changes in such a way that we can keep this model, but as a wheel which moves. A rapid increase of change in the social structure, however, induces a shift of functions from one institution to another. When one institution fails to meet a human need, another institution will often assume the function. Sometimes such a shift will arrest the dysfunction in both institutional areas and thus help to restore a balance for the total society. In this situation we can still keep our model of the moving wheel.

The penetration of one institution into another can also create dysfunctions. This is what seems to have been happening at least over the last two decades, so that our model of the wheel is no longer valid. Economic and political institutions are penetrating into the family institution and the consequences are seen in the general social structure. This invasion by economic norms and values has led to an impairment of the family's role in personality development, an increase in strain and tension, the lessening of family stability and threats to social cohesion. The family has been reduced to a mere consumer unit, no longer able to provide the necessary psychological comfort and wellbeing for its members. This situation has direct repercussions on a certain number of individuals who, because of their age and/or character, are going through periods of physical and mental maturation.

Over the last two decades we have had a tremendous increase in economic growth and technical development. This has "necessitated" a high degree of differentiation and division of labour. It has led to an

increased demand for education and specialization and, at the same time, encouraged the individual to set high levels of personal aspiration and expectation. These high demands mean, on the one hand, that the difficulties faced during the period of adolescence are greater today than they were before and on the other hand, that this period undoubtedly shows a tendency to last longer. If we agree with Hollinshead[1] that "adolescence is a period in the life of a person during which society ceases to consider him as a child while refusing to grant him either the status, or the roles, or the functions of the adult", we must also accept that this slow maturation process may today extend over 14 to 25 years.

It thus seems as if we have created a vulnerable group. At the same time, the levels to which young people have been encouraged to aspire have only been attained by a minority and the majority have been frustrated in their expectations. It is not surprising, therefore, that the prevailing value system has been rejected by large groups of the young people who have formed their own norms and values.

The hardest hit by the present situation, according to the most recent reports, seem to be those coming from low-income, often broken families, who have a comparatively low level of education, and are often socially isolated or in conflict with their social environment. It is among these groups that we find the highest incidence of drug dependence, alcoholism, absenteeism, juvenile delinquency, venereal diseases and, as previously mentioned, of suicide and attempted suicide.

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[1] Hollinshead, A. B. (1964) A sociologic perspective of adolescence, Pediat. Clin. N. Amer., 7, 131-146

ANNEX IV

PREVENTION, INTERVENTION AND SUBSEQUENT ACTION (POSTVENTION) IN SUICIDAL BEHAVIOUR

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1. Introduction

Two different models of suicidal behaviour, a "disease model" and a "behaviour model", can be utilized for the treatment of suicidal behaviour.

2. The "disease model" of suicidal behaviour, and primary, secondary and tertiary prevention

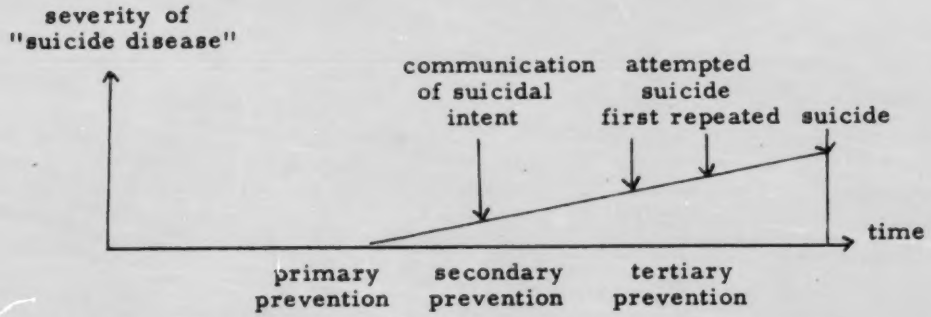
Because medical pathology is attaching increasing importance to the chronic diseases, the concepts of primary, secondary and tertiary prevention have become widely used in the health field. They have proved useful in such different areas as cardiovascular diseases, cancer and most psychic disorders (1), where they can provide a useful framework for the prevention of disorders from coming into existence (primary prevention), for early detection and treatment (secondary prevention), and for rehabilitative activities in order to prevent chronic disability (tertiary prevention).

Most existing suicide prevention agencies seem to work with a "chronic disease model" of suicidal behaviour implying that thoughts of suicide, communicating suicidal intent, attempting suicide and finally committing suicide are not different types of behaviour but all belong to the same "suicide disease", the former being less serious early signs of the latter. Suicide prevention activities therefore concentrate on clients showing the allegedly early signs of a subsequent fatal suicide, mainly on attempted suicides. Primary, secondary and tertiary prevention can be applied to such a "disease" (see fig. 1).

Annex IV

Fig. 1

THE RELATIONSHIP BETWEEN THE "DISEASE MODEL" OF SUICIDAL BEHAVIOUR AND PRIMARY, SECONDARY AND TERTIARY PREVENTION



3. The "behaviour model" of suicidal behaviour and prevention, intervention and postvention

Organized help can only be directed towards perceived phenomena. Suicidal thoughts and tendencies cannot therefore be a starting point for instituting helpful action unless they are communicated. Only overt, that is visible, suicidal behaviour can serve as a target for organized help.

For our purpose three types of overt suicidal behaviour can be distinguished: communication of suicidal intent, attempting suicide and suicide itself. Although there is a certain overlap between these three there is good evidence that they are different entities of behaviour which require different strategies of help. Follow-up studies (13), epidemiological data (8) (4), and analyses of the suicidal "set-up" (9), suggest that communicating suicidal intent, attempting suicide and committing suicide are instant and independent events and not interrelated phenomena within a so-called suicide disease. The simple epidemiological finding alone that suicide occurs predominantly among old men and those who have a formal psychiatric diagnosis, as compared with attempted suicide, which is more frequent among young women mostly without a formal psychiatric diagnosis, is already a strong point in favour of this distinction.

Attempting suicide can be understood as a strategy for getting out of emotionally troublesome situations, as a bodily and therefore risky appeal for assistance (11) or "cry for help" (2). As bodily self-damage forces significant others to show indulgent behaviour, this strategy has an almost certain "success", which is, however, short-lasting because it is extorted and not voluntary. This and the dangers of bodily self-damage make attempting suicide a pathological strategy for crisis resolution (5).

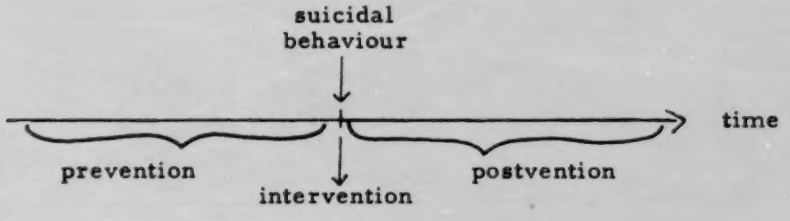
An alternative strategy for getting out of emotionally troublesome situations consists in contacting helping agencies (such as suicide prevention centres and general practitioners) and asking for help directly. As recent research suggests, persons using this strategy are quite different from those who attempt suicide, the latter not being willing or able to ask for help in an open and direct way (8).

Trying to get help is only meaningful if there is a definite chance of getting it. If a person is socially dead (5), an appeal for help would be useless and to complement one's social death by dying physically would then be the only way of "getting out of an emotionally troublesome situation".

In other words, persons experiencing a total lack of social integration (which holds for many old people) are the most likely to commit suicide. Persons experiencing a low degree of social integration (but not a total lack, which is true for many young people in their transition to an adult identity) are more likely to ask for help in the rather risky way of bodily self-damage, because less dramatic signs of their distress, for example by asking for help verbally, might not be taken notice of by those around them. If helping action is to be directed towards rather precipitate and independent phenomena (and not to a disease which shows a certain development over time) the concepts of prevention, intervention and postvention provide a truer and clearer framework for the helping activities. These concepts simply categorize helping activities according to their time relation with the pathological phenomenon. All possible steps to be taken before the phenomenon in question occurs - in order to prevent it from coming into existence - can be subsumed under the term prevention. Intervention would mean all actions being taken while the pathological phenomenon occurs. Postvention then signifies all actions performed after a certain pathological phenomenon has occurred. In fig. 2 these concepts are related to suicidal behaviour.

Fig. 2

THE RELATION BETWEEN OBSERVABLE SUICIDAL BEHAVIOUR AND PREVENTION, INTERVENTION AND POSTVENTION



4. Prevention, intervention and postvention in suicidal behaviour

4.1 Prevention

Fatal suicide is, in two-thirds of the cases, not preceded by one or more suicidal attempts. The communication of suicidal intent seems to be more predictive of subsequent suicide than an attempt (12). There is some evidence that other groups than those who attempt suicide have an especially high risk of an eventual fatal suicide; these include alcoholics, psychiatric patients with endogenous depression, residents in anomic areas with high rates of single room occupancy and inhabitants of old age homes and city shelters. To devote suicide prevention activities only to people who make suicidal attempts, might mean that the greatest effort was being concentrated on the wrong population (6).

It seems, therefore, that the most rewarding strategy for preventing a fatal suicidal act is to undertake primary, secondary and tertiary prevention for the long lasting and recurrent psychiatric disturbances, mainly alcoholism and endogenous depression. For the latter condition, for example, lithium treatment must now be regarded as an effective preventive measure (10). This prevention can be most effectively organized in a comprehensive and regionalized mental health service rather than in an independent suicide prevention agency. The social problems mentioned above as being correlated with suicide also suggest the advisability of such a broad psychosocial service approach. The main features of this method of tackling the problem are coordination of help and continuity of care offered by different professional staff and institutions and the reduction of the social distance between helpers and clients by promoting primary care facilities within a geographically limited area. High-risk groups can be identified and actively sought out for the purpose of offering help on a local basis. General practitioners, social workers, teachers and all other persons working with people should be educated in the recognition of potential suicides.

So far as suicidal attempts are concerned, epidemiologically speaking preventive activities must concentrate on a different population and chiefly on young people. They must aim at helping people to avoid the dangerous bodily appeal for help by offering them and educating them in alternative means of resolving their crises. In general a more open style of communicating with one another should be promoted.

Here again a regionalized and comprehensive service with easy access for everybody seems to be the most promising preventive measure, especially as attempting suicide obviously seems to be a phenomenon of local subcultures in which self-injury is a common means of dealing with a personal crisis (7).

4.2 Intervention

Intervention in attempted suicide consists of two steps: somatic treatment to reverse the effects of the self-inflicted injury, and psychiatric assessment in order to detect possible mental illness. There are different organizational models for offering this intervention. In Vienna a central

detoxification unit was established by Ringel over 20 years ago and nowadays up to 90 % of all officially known attempted suicides are brought to this centre, which forms part of the Psychiatric Clinic of the University of Vienna. While this location guarantees psychiatric assessment, it may on the other hand stigmatize many patients as mentally abnormal although they have not received a formal psychiatric diagnosis.

The question of communication of suicidal intent raises a very difficult problem. How seriously should these communications be taken? Should everybody who declares a suicidal intent be compulsorily committed to a psychiatric hospital? As stated above, empirical evidence suggests that people who say they intend to commit suicide carry a higher risk for subsequent fatal suicide than do those who make an attempt. Communication of intent therefore suggests that at least some attention should be paid to a person acting in this way. If he is referred to other helping agencies, active efforts must be made to see that he really gets help. All people who work in medical and social agencies should get some training in how to react when a person says he means to commit suicide.

4.3 Postvention

Recent bereavement may leave the survivors at high risk of copying the suicidal behaviour. Hence care devoted to significant others should have a preventive value. In Vienna the suicide prevention service engages in this task.

Helping activities after an attempted suicide should not only be regarded as prevention of subsequent suicidal behaviour. Help as a response to a cry for help may have a value in itself. If one's aim is to prevent a suicidal attempt being followed by a fatal suicide, it is essential to identify this small subpopulation with a high risk of subsequent suicide. Unfortunately we do not yet dispose of sufficiently reliable methods for doing this.

If such persons with a high risk of subsequent suicide can be identified, for instance they might be old, retired persons, help should be provided immediately and carried on for some time. This is because it is usually in the first few months after the suicidal attempt that the fatal suicide occurs. Continuity of care therefore seems to be very important here, as well as cooperation between medical, psychiatric and social services, again a task which can best be tackled in a regionalized comprehensive service system.

The highest proportion of suicidal attempts occurs among young women using drugs in an interpersonal-conflict situation. They form a compact group which can be identified by mathematical techniques (3). They seem to correspond to the "cry for help" type of attempted suicide and need a special form of care. They have asked for help in a dramatic way, and they get it - but usually the wrong type. Significant others can hardly fail to show conspicuously indulgent behaviour in this situation, especially as the intervening psychiatrist is likely to exert additional pressure on

them. The result is that everything seems to be going on satisfactorily, and so no analysis is made of the situation which forced the patient to use such a dangerous means of getting out of an emotionally troublesome situation. Help which is extorted does not last very long and soon partners and parents revert to their former behaviour, thus causing the patient to use the extorting strategy again.

In this type of attempted suicide a group-centred postvention technique seems to be reasonable, especially as the suicidal attempt offers an outstanding opportunity to confront whole groups of persons (usually families) with pathological patterns of interaction and make them understandable. In sessions with all significant others the patient's difficult emotional situation should be pointed out to them. In the same way the patient should be made to see that part of his suicidal behaviour is designed to extort care and sympathy, since extorting mechanisms may be of a more general importance in families where there are suicidal attempts.

With regard to the communication of suicide intent, a similar effort must be made to identify subgroups with a high risk of subsequent suicide. People with depressive illness often express the intention of killing themselves. Sensitivity for understanding these signs, and knowledge about symptoms and treatment of depressive illness should be more widespread, especially among physicians of all specialties and among general practitioners. The methods of helping should be similar to those used in various subgroups of attempted suicide, with particular stress on the period immediately following the communication of the suicidal intent (13).

5. Conclusion

Resources for helping people who threaten or attempt suicide are in short supply. In order to make good use of those which exist we must know how to allocate the right help to the right problem. Differentiation and subclassification of both suicidal behaviour and the help available is necessary to achieve this. In this paper an attempt has been made to provide a starting point for such differentiation.

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ANNEX V

SUICIDE PREVENTION SERVICES AND THEIR EVALUATION

by
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Only for a very few years has it been possible to speak of "suicide prevention" in practical terms. No medical measure has been shown to influence suicide rates, not even electric shock treatment which is the most rapidly effective method of treating psychotic depression - the illness carrying the greatest risk of suicide. Those of us who spend most of our time in clinical psychiatry must believe that our treatment can save the lives of suicidal people but, with the possible exception of intensive group psychotherapy to which I shall refer later, statistical confirmation of what we do is very much lacking.

Until the suicide figures for England and Wales started to drop in the late 1960s the only proven suicide prevention measure was a state of war. Conversely, a rise was to be expected at times of economic decline and industrial stagnation. Most people expected a rise in Britain during the 1960s and 1970s but, astonishingly, the rate went on down from 1963 to 1972 in step-wise manner, totalling a drop of over one-third.

It is important to examine the reasons for this decrease because they are especially relevant to the case of young people. Factors which we may isolate include better medical treatment (consumption of anti-depressants certainly went up during this period), better intensive care such that it is now extremely difficult to die from an overdose of commonly prescribed psychotropic drugs, less use of lethal barbiturates and their replacement by drugs of low lethality like benzodiazepines, greater willingness of distressed people to seek help and of their acquaintances to seek help on their behalf, the welfare state with better provision for the suicide-prone elderly and, above all, North Sea gas.

Examining suicide by method, year by year, it is possible to account almost exactly for the decline in suicide by the decline in death caused by domestic gas. Natural gas can still kill by asphyxiation or explosion but it does so very seldom.

All the factors mentioned, however, apply with equal or greater force in countries other than Britain which have seen either no suicide drop or a slight rise. In the Netherlands, which went completely over to natural gas in the mid 1960s, the 1970 rate was higher than that for 1960, though not significantly so, people having turned to suicide by other methods as they did in Basel when carbon monoxide was removed from the gas as a suicide preventive measure. The Scandinavian medical services in general are probably better than the British and their welfare services equally or even more comprehensive. Intensive care is also extremely highly developed in France and the USA.

The one factor which is unique to Britain is the Samaritan organization, a nationwide network of some 150 suicide prevention centres offering an advertised, 24-hour service to the distressed and suicidal which is completely confidential and in no way part of the State set-up. We know of many clients, especially among the young, who will appeal to Samaritans because they are suspicious of doctors and other established professionals. If we add to these branches the large number of satellite befriending groups and sub-offices in smaller towns, it is only a minority of people in the country that are not within a few miles of Samaritan help.

New clients contacting the organization increased steadily each year from 12 000 in 1964 (when records were first kept) to over 156 000 for 1972 and for 1973. This is about one in three hundred of population or roughly one family in a hundred. It cannot be said that a plateau has been reached, because the 1972 figures were artificially increased by an eleven-episode television series based on the work of an imaginary Samaritan branch. Interesting new developments include a correspondence branch covering the highlands of Scotland and operating from a box number, and a pop festival branch manned by young people that exists only on the site of these strange, orgiastic, communal sessions.

That Samaritans have been responsible for at least a good part of the national decline in suicide rates is supported by the work of Bagley who compared the suicide rates before and after the opening of early Samaritan branches in 15 towns with the corresponding rates for 15 "control" towns, closely resembling the former, but without a Samaritan service. At the time the data were recorded, in the early 1960s, the "non-Samaritan" towns showed an increase over the period of nearly 20%, compared with a decline in "Samaritan" towns of nearly 6%. The difference between these two percentages is statistically highly significant. Following some criticism of the way in which the control towns had been chosen, Bagley made a check on his results, using a fresh set of controls which had the closest correspondence to the Samaritan towns on the ranks of sex, age and class structure. This new comparison study showed that the suicide rate in the new centres rose in the relevant period by an average of 7.23% compared with the 5.85% fall in the Samaritan towns, a difference which is significant at the 5% level. American suicidologists such as Schneidman accept the validity of this work.

Other countries have analogous suicide prevention services, so that no major European country is without some kind of emergency telephone line. The main suicide preventive effort outside Britain has been in the USA, where for example the single Suicide Prevention Centre (SPC) in Buffalo has an annual budget of $400 000, about one-third the total budget of the Samaritans in Britain. The history of the services in the two countries covers roughly the same length of time and a large amount of research has been carried out, notably the Los Angeles studies on lethality and prediction. The preventive effort appears to have been largely concentrated on the West Coast, for example California has 33 SPCs which may be regarded as efficient. Nevertheless, the suicide rate per 100 000 of 15.9

in 1960 rose to 18.8 in 1970. The increase among young people was especially impressive: at ages 15-19 it rose from 5.5 to 12.0 and at 20-24 more than doubled, from 10.9 to 24. The increase in suicide among young blacks gives rise to particular anxiety.

There are a number of factors which may help to account for the different results between the two countries.

1. The American services do not have a national image or national news coverage, whereas in Britain the word "Samaritan" and the image of a capital letter S with a telephone dial in the lower curve are common to the whole of the country. Hence a mention of Samaritans in any of the mass media means free publicity for all branches. In 1971 two-thirds of the adult population knew what Samaritans were and, of these, two-thirds said they would contact them if they felt they needed to. By contrast it seems that American knowledge of SPCs is low.

2. American branches vary in name, use of volunteers, techniques, publicity, etc., and attempts to develop a unified approach, for example by means of a coordinator, met heavy opposition from centres who felt their autonomy threatened. Samaritans, on the other hand, have nationally prescribed and supervised standards for thoroughness of selection and training, adequacy of leadership, efficiency of the 24 hours availability and relationship with local professional organizations. Check-up visits are made, and unsuccessful branches put on probation or even closed down.

3. The American service has, until recently, been entirely a telephone service. Recently the San Mateo Centre started a "drop-in" centre and befriending of the lonely as do the Samaritans. Since suicide is highly correlated with social isolation it is felt that a face-to-face dialogue with and befriending of this suicide-prone group has much to offer.

4. In American centres action may be taken without the client's permission. If a person takes an overdose while in the telephone call-box (a not unrare event), Samaritans would send their flying squad or, if the client became unconscious, an ambulance. As in America this would cost about $ 80, whereas the police will take the client to hospital free; the latter has become the established practice. The client therefore becomes immediately subject to compulsory orders and may, against his will, be confined in a State mental hospital. Anecdotal evidence suggests strongly that aggrieved patients spread the news that to ring an SPC is to get taken away and locked up. SPCs, however, fear that failure to take this action may lead to law suits for negligence. Samaritans, however, never take action with regard to either doctors or police without the client's consent and this includes those who come and confess to murder who, when genuine, are almost always persuaded to give themselves up to the authorities.

5. American centres are all professionally run and supervised. Whatever the involvement of the professionals there is a basic difference between doing a job for money and in a purely voluntary capacity, and this is likely to be sensed.

6. An important factor to be taken into account in evaluating American suicide prevention services is that a relatively high proportion are by firearms and explosives; in California over a third of all suicides and about one half of those in men are by this means. This does not allow for the "second chance" permitted in Britain by the overwhelming proportion of overdoses.

Most of the foregoing observations may apply also to European telephone services. The professional influence seems to lie in general midway between the American and British customs. There is also in some countries the factor due to services being organized by and linked with a particular religious denomination. The fear of being proselytised may be a deterrent to many people.

In examining the role of Samaritans in relation to young people it must be remarked that suicide rates in Britain in the 15-24 age-group rose steadily after World War II, in common with those in other western countries. It stabilized in the mid-1960s and has since shown an irregular decline. Subgroups with the highest rates also showed the steepest decline. The proportion of young people aged under 25 among 12 355 Samaritan clients in 1966, was a little less than 20%, which is slightly more than might be expected from their proportion in the population. A similar analysis of 31 000 new clients in 1969 showed about 30% under 30 and 10% under 20. Expectation according to the population for the latter group is about 17%, so that they were proportionately under-represented.

An analysis of nearly 74 000 new clients in 1972 showed an increase in the proportion aged under 25 to over 30% and astonishingly there were 929 clients aged 12 or under, which represents about 2% of all clients whose age was recorded. This figure can only be compared with that of 52 children aged 9 or under in 1969. Looking at the problems presented by clients aged under 25 in 1966 showed that, in comparison with other age-groups:

under-represented were alcohol, depression, physical illness, legal problems unspecified, work difficulties and relationship difficulties with sexual partner;

grossly over-represented were pregnancy problems and relationship difficulties with parents.

There were only 30 cases of drug problems, and the history of suicidal attempts was the same as for all age-groups. The problem pattern among the young remained very much the same in 1969, with no relative increase in drug cases. The 1972 analysis continues this pattern, but shows that homosexuality has become more of a problem with about half of the nearly 1000 clients aged under 25, 14 of whom were in the age-group 12 or under. Problems of housing and living accommodation increased from 19% in 1966 to 28% in 1972.

Annex V

The striking increase in the number of younger clients in 1972 may be due to cultural changes which produce, among other things, much more overdosing at this age. It is, however, more likely to be a consequence of a television series called "The Befrienders" which brought knowledge of the Samaritans to most children for the first time, since there had been little previous publicity aimed at those aged under 16. Most children came because of conflicts of one kind or another with their families, varying from the most alarming of social disasters to a fear of reporting the loss of a schoolbook.

University students are proportionately grossly under-represented among Samaritan clients. Fifteen branches in university towns produced data for 1970 showing referral rates ranging from 1 client per 250 students in Portsmouth to 1 in 8350 in Liverpool. The problems presented followed the national distribution, except for depression which emerged as the principal one.

To meet the needs of students a Samaritan-style "night-line" service operating on the internal telephone system was introduced, modelled on that pioneered in Utrecht. The first British service was opened in the University of Essex in 1969, and received 80 calls in the first 101 nights, although the neighbouring Samaritans had received no calls from students since they opened 5 years previously. By 1973 these "night-line" or "contact" services had 23 branches operating and probably all major universities had one. Volunteers in some of these are trained in the local Samaritan branch, but in other cases the students feel the Samaritans are too middle-aged and "establishment" and they perfer to work on their own. It is clear that services by youth and for youth are finding a new area of need, but evaluation is made difficult by the reticence of university authorities in allowing research into suicide and attempted suicide in their establishments. A study published in 1959 showed that the Universities of Oxford and Cambridge, characterized by a tradition of high academic standards and therefore regarded as being institutions of high pressure, had high suicide rates, whereas the recently founded universities, commonly called Redbrick, had rates not much above the national average for age, while the University of London, which comes between the very old and the very new foundations, had rates in between. Efforts have been made to interpret these results in terms of such factors as distance from the parental home and differences in tutorial systems. Unfortunately this report has not yet been brought up to date.

This paper has not been able to dwell on the large and expanding area of attempted suicide among young people. Evaluation presents special problems, one of which is an acute lack of hard data. Discussion among physicians tends to support the idea that the rates reached a plateau in 1973.

ANNEX VI

SOME RESEARCH ASPECTS OF SUICIDE AND ATTEMPTED SUICIDE (PARASUICIDE) WITH SPECIAL REFERENCE TO YOUNG PEOPLE

by
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In discussion of research in the field of social psychiatry, studies of suicidal behaviour are sometimes held up as an example of how much can be achieved. Those of us working in the area, however, might say without undue cynicism that we know everything about suicidal behaviour except why people engage in it and why some forms of it are increasing.

In a discussion of these problems it is necessary to preserve a clear distinction between completed suicide on the one hand and non-fatal self-aggressive behaviour, variously termed "attempted suicide" or "parasuicide" on the other. The comparison of these two forms of behaviour and an understanding of how they differ yet overlap is one of the central tasks of current suicide research. In this paper it is proposed to discuss two topics from each area, and to do so in an illustrative way rather than to attempt to present detailed research results.

Suicide

Before considering any specific aspects of suicide, it may be helpful to indicate the trends in recent rates for Great Britain. The data for England and Wales, which refer to about 95% of the total United Kingdom, show that over the last two decades the crude rate for men has fallen appreciably, while that for women shows no such trend. Many other European nations show a similar pattern. However, the crude rates completely fail to do justice to the trends which are occurring among young people. Fig. 1 compares the age-specific suicide mortality for men in 1955 with that of 1971. It can be seen that there has been a decrease in the rates at most ages except for the 15-24 age-group. This difference is brought out more clearly if the 1971 rates are expressed as percentages of those in 1955. Fig. 2 shows that the change in the rates for both men and women differs markedly from one sex-age-group to another, with young people aged 15-24 showing the greatest proportional increases. Similar increases in suicide among young people, especially males, have been reported from other European countries, most notably those of the northern and north-west fringe (WHO, 1968, 1970).

Typology of suicide

A possible reason for the absolute and relative increase of suicide in young people might be that alcohol consumption and drug abuse has become much more frequent in these age-groups over the last two decades.

Annex VI

Fig. 1

AGE-SPECIFIC SUICIDE RATES PER 100 000 FOR MALES, ENGLAND & WALES, 1955 AND 1971

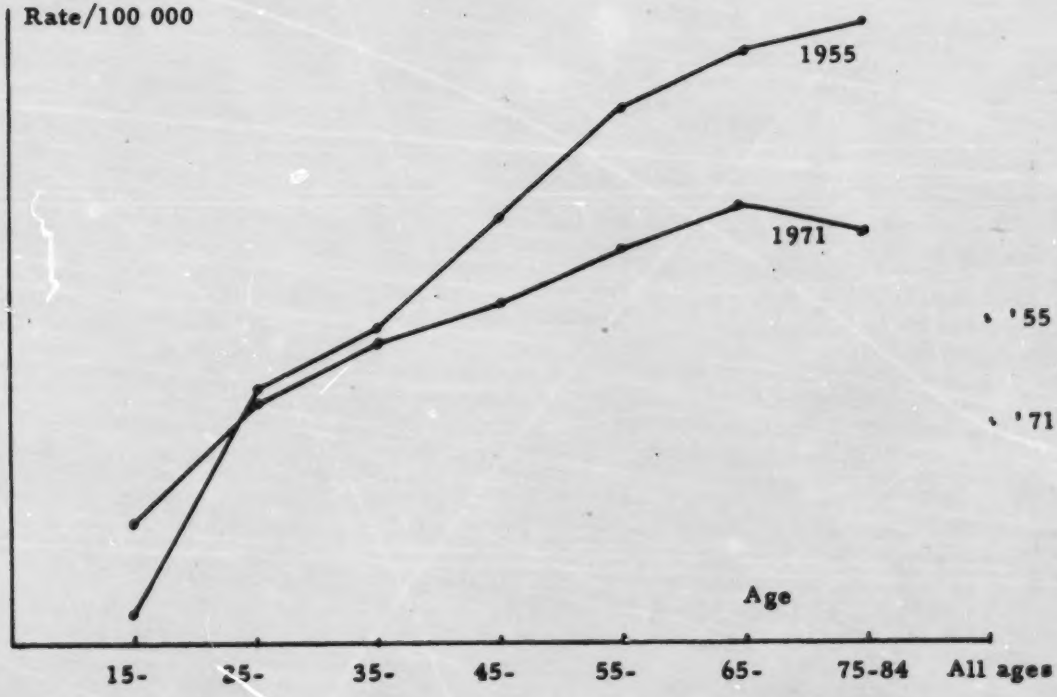

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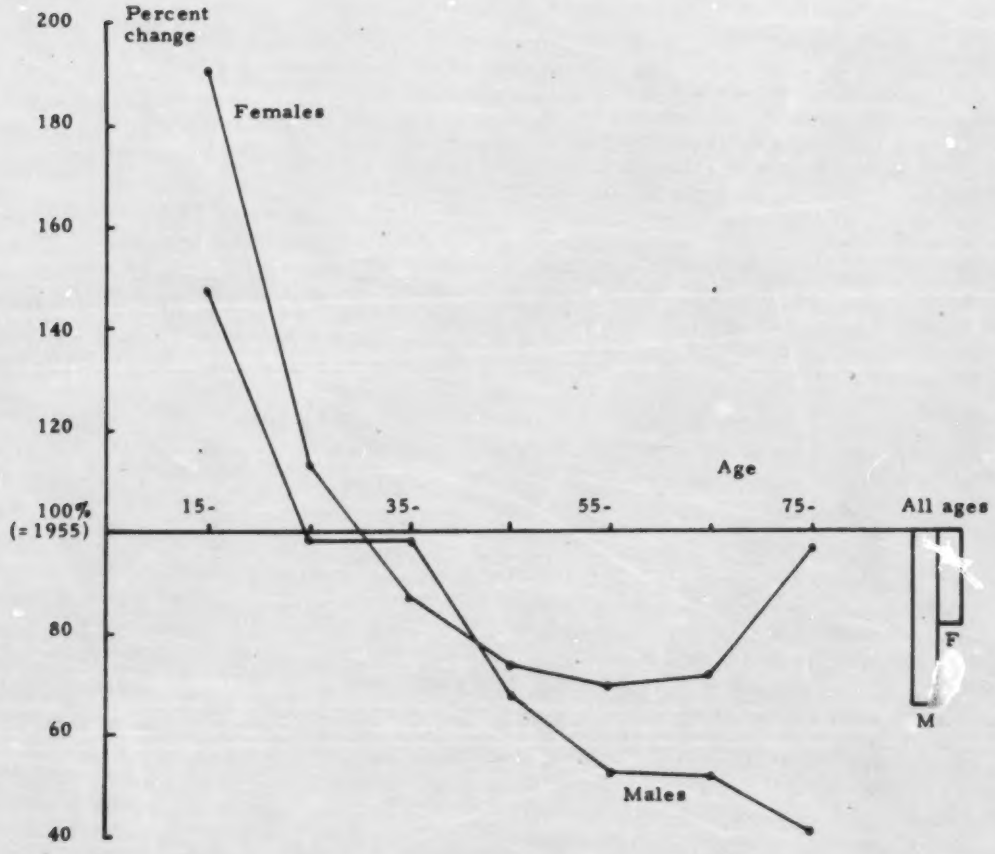
Fig. 2

AGE-SPECIFIC DEATH RATES IN 1971 AS PERCENTAGES OF THE CORRESPONDING RATES FOR 1955, ENGLAND & WALES, BY SEX



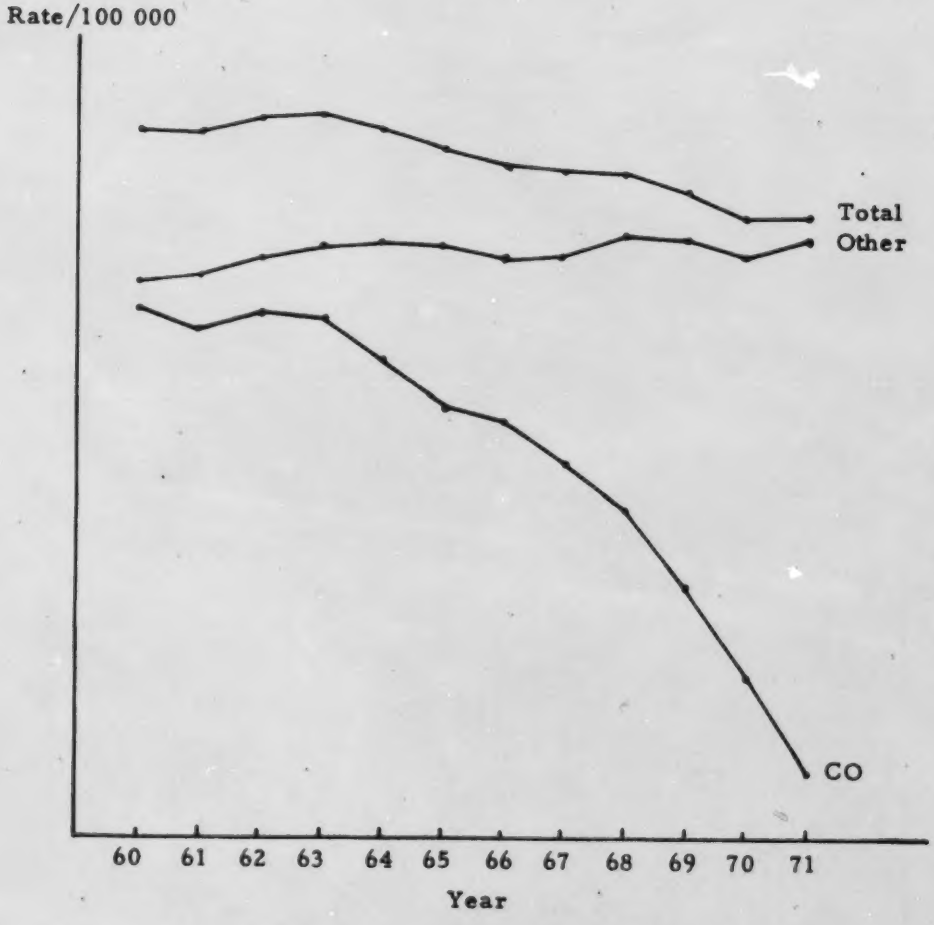
Sundby (1972) has summarized the evidence on this question. A study on a slightly tangential theme was recently conducted by Dr Ovenstone and myself (Ovenstone & Kreitman, 1974). We examined a series of suicides to ascertain whether they really formed a uniform series with respect to a large number of clinical and social characteristics, or whether they should more appropriately be regarded as comprising two or more distinct varieties. Using a simple form of numerical taxonomy we found two main variants of completed suicide. The first group was composed of individuals who had apparently led stable lives, though often their adjustment was precariously dependent upon the continued existence of one or two key figures (for example, a single man living with his aged mother) and was not supported by any other social contacts. These people had then been subject to an acute stress such as a bereavement or a physical illness to which they made a poor adjustment, becoming conspicuously depressed and sometimes resorting briefly to heavy drinking before they killed themselves. The second group were different in that all their lives they had led socially marginal existences, with an unstable home background, long periods of unemployment, difficulty in conforming with the law, numerous debts, pathological drinking and often repeated suicidal attempts. Their deaths occurred in relation to some stress which did not appear to be conspicuously different from those experienced throughout their lives. An important negative finding was that these two groups did not differ in age, so that caution is necessary when drawing conclusions concerning the role of alcohol (and social disorganization) in influencing the suicide mortality rates among young people. Nevertheless, we know from other studies that suicides in alcoholics occur at a relatively younger age than other suicides (Murphy & Robins, 1967; Kessel & Grossman, 1961), and that alcoholism beginning early in life tends to run a more malignant and socially devastating course than when its onset occurs in the middle years (Hassall, 1969). Taken together these pointers suggest a line of inquiry worth vigorous pursuit.

Specific causes of death

Another intriguing feature of the UK experience of suicide mortality in recent years is that the decline in the crude suicide rate since 1962 is entirely attributable to a decrease in the number using domestic gas, which in turn is probably due to the increasing safety of the gas supplied to domestic users from that date. The trends for men and women in England and Wales and in Scotland all show much the same pattern. Fig. 3 shows the trend for males in England and Wales. Quite clearly the carbon monoxide mortality rate has decreased substantially, while that associated with other means of suicide has barely changed or has increased only slightly. The combined effects of these two trends is shown in the upper part of the diagram as a decreasing rate for suicides irrespective of the causative agent.

Fig. 3

SUICIDE RATES BY CARBON MONOXIDE POISONING
AND "OTHER" MEANS
ENGLAND & WALES, 1960-1971, MALES



Annex VI

Fig. 4

CARBON MONOXIDE SUICIDE RATES AND THOSE DUE TO OTHER AGENTS
ENGLAND & WALES, 1960-1971, MALES

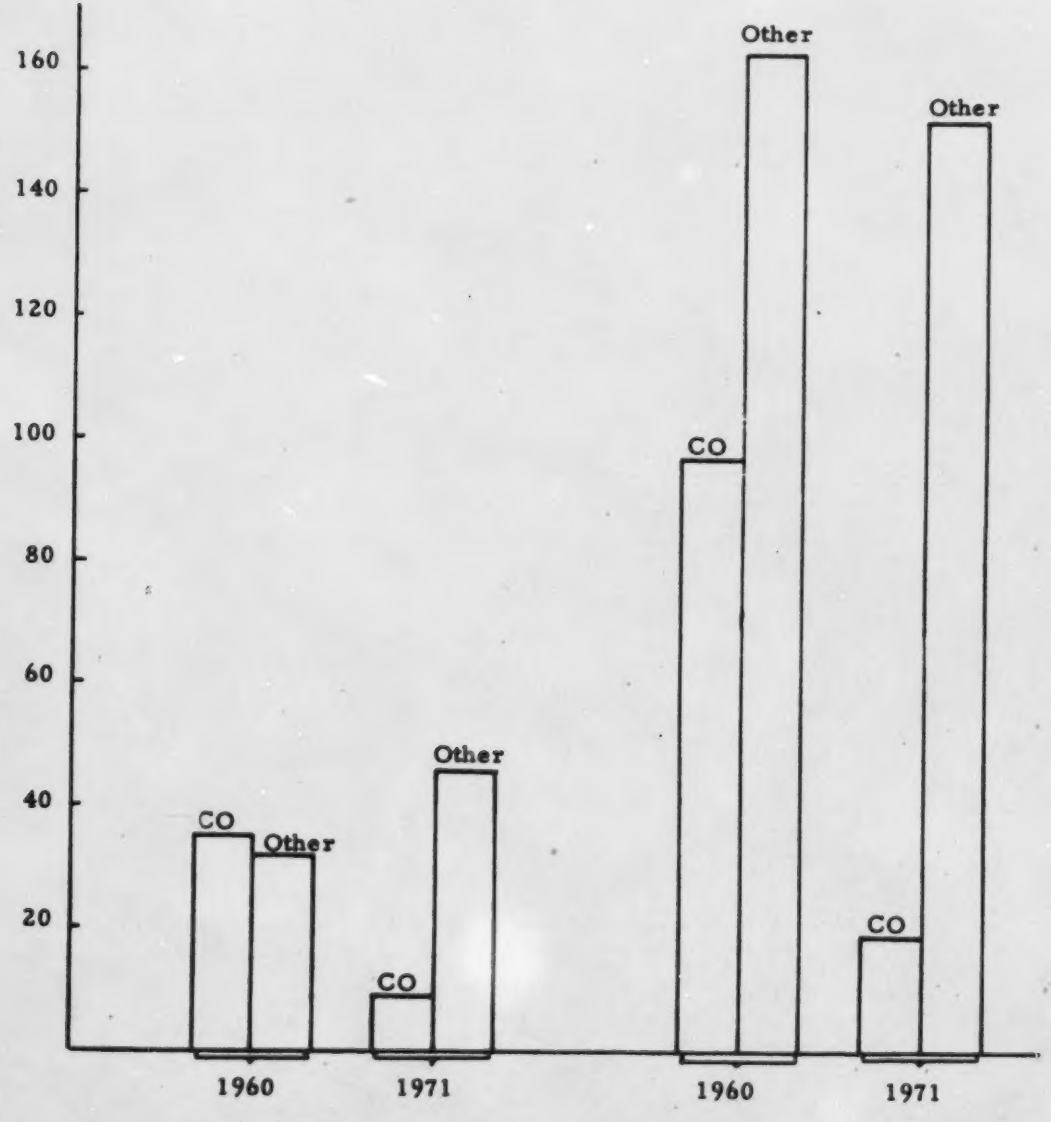


Fig. 3 shows that for the population at large, who have steadily been deprived of lethal domestic gas, there has been only a minor tendency to "compensate" by resorting to other methods. When age-specific rates are considered the picture is different. Fig. 4 shows the rates for two selected age-groups, 15-24 and 55-64, in 1960 and 1971, due to carbon monoxide and to all other agents. In the older group both types of suicide have declined markedly and there is no evidence that the decrease in deaths from CO poisoning is compensated for by resort to other agents. In the younger age-group the decline in CO deaths in 1971 compared with 1960 is balanced by a corresponding increase in non-carbon monoxide deaths.

The implication of these findings remains to be worked out and there are many other issues to be taken into account before firm conclusions can be drawn. It would appear that there are two possible hypotheses regarding the young people. Firstly, and in line with the speculations about alcohol and drug abuse, it might be that the reduction of traditional types of suicide has been more than offset by the emergence of a new group of individuals, the young alcoholics or addicts who kill themselves. Alternatively, it might be that it is essentially the same group of young individuals who commit suicide, but that having been deprived of domestic gas as a potential means, they have switched to alternative methods. The former hypothesis is perhaps more plausible, but the second raises interesting questions concerning the psychodynamics of suicide (at any age) in relation to a specific agent. There is never a shortage of exits from life for a determined person; why then has the removal of one lethal agent led to a decline in the total suicide rate? We know almost nothing about such questions.

Attempted suicide (parasuicide)

It is important for research to monitor trends in suicidal attempts, especially if they can be related to a known population. Consideration of these rates over a number of years illustrates aspects of the attempted suicide situation which cannot be detected by cross-sectional studies.

Three distinct kinds of rates must be distinguished:

(1) the admission rate which relates the number of events of admission to the number of individuals in the population at risk; this rate is useful for administrative purposes, but conceals the fact that the same patient is sometimes admitted more than once in the course of a year;

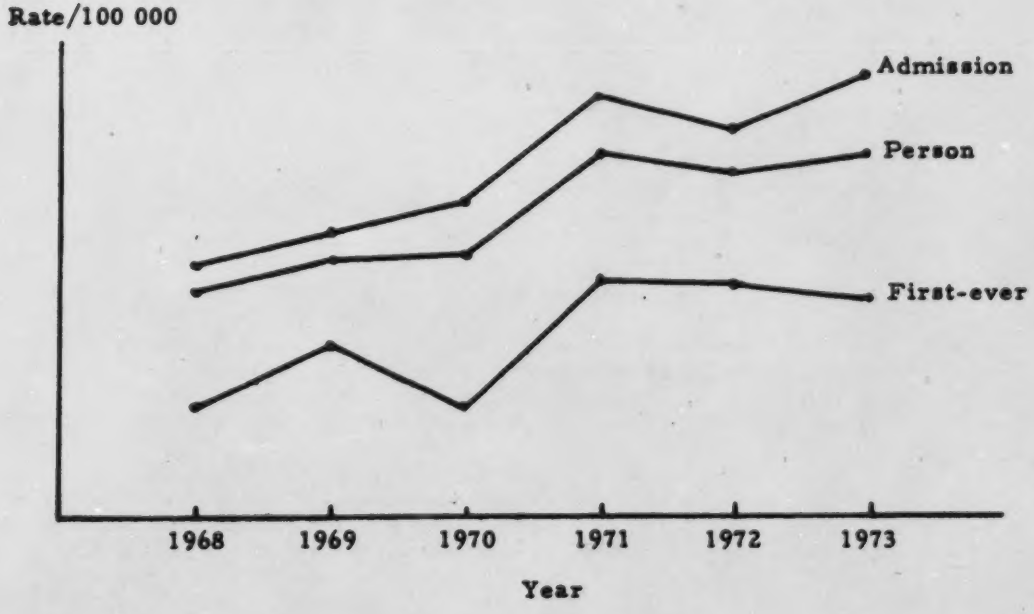
(2) person rates, in which each individual is counted only once in the year; however, as an appreciable number of individuals appear sporadically in a treatment centre over a number of years, they would be included in the person rates for several different years;

(3) "first-ever" rates for which an individual is enumerated only if his suicidal attempt is the first one known, for example the first one ever carried out, whether treated or not, at any time in the individual's lifetime.

Fig. 5 compares these three sets of rates for women aged 20-24 in Edinburgh from 1968 to 1973. It can be seen that over the six years the admission rate for this group has doubled, a finding by no means unique at this centre, and representing an increase which is not remarkable compared with some other groups, such as the 15-19 years old. However, the increase shown by the person rates is rather less striking, with a rise of approximately 50% from the beginning to the end of the period. The first-ever rate, on the other hand, shows only a modest increase, perhaps a third over the period. Other age-groups among both men and women have also been examined in this way, and the general picture is much the same despite some interesting divergences.

Fig. 5

FIRST-EVER, PERSON AND ADMISSION RATES FOR ATTEMPTED SUICIDES IN EDINBURGH, 1968-1973, FOR WOMEN AGED 20-24



The final year's data refer to 1973 and as they have become available only very recently, it would be premature to offer any firm conclusions, but it appears at present as though the explosion in attempted suicides, now documented for so many areas in so many different countries, may not be primarily due to a dramatic increase in the number of individuals who are involved in self-aggressive acts for the first time in their lives, but might equally well reflect an increased liability to repeat such behaviour once the initial act has been undertaken.

Thus the central riddle of recent developments in parasuicides could break down into two quite separate questions. The first is why do people in increasing numbers engage in such behaviour for the first time, even if that increase is not as dramatic as was at first supposed. The second and quite separate question is, what are the factors conducing to a greater willingness to return to such a pattern of behaviour, especially since clinical studies suggest that the social solution effected by a parasuicidal act is invariably short lived and unsatisfactory (McCulloch, 1965) and that at least for the more seriously poisoned cases the experience of being resuscitated is distinctly unpleasant (Greer & Lee, 1967). It is easier to pose these questions than to answer them, but it is essential that they should first be accurately formulated, and then solved.

The prediction of repetition

In most centres medical services are being overwhelmed by the increasing number of attempted suicides coming to their notice. It is not physically possible for all such patients to be given intensive aftercare. Therefore, some method of selection based on the prediction of who is at greatest risk of subsequent attempts or of accomplished suicide (or some similar outcome) would clearly be desirable. Certainly prediction is a logical priority, even if there are grounds for scepticism as to whether aftercare services of the usual pattern are in fact efficacious.

A number of investigators have attempted to derive predictive criteria, chiefly in relation to repetition of suicidal attempts. In some of these studies considerable statistical sophistication has been brought to bear, but it would seem that there are two limitations on their success. The first derives from what is known of the precipitants of suicidal behaviour. The great majority of such episodes appear in the context of an interpersonal crisis, usually of a domestic quarrel or of friction between courting couples. The predictability of such events is necessarily limited. The clinician has before him data relating primarily to his patient, and though he may be able to glean some information by talking to relatives and witnessing the (often distorted) pattern of relationships displayed at the bedside, he is nevertheless in a relatively weak position to predict repetition since he has only half the information necessary for this purpose. To the patient a bout of drunken aggression by her husband or an episode of infidelity by his wife, may be a highly significant event, but for statistical purposes they may have to be regarded as random occurrences. A high level of successful prediction seems almost impossible under these circumstances.

This leads to the second point, namely the value of predictive studies which cannot achieve more than a modest level of success. This point may be illustrated by some hypothetical data. My colleague, Miss Dorothy Buglass, has by means of a series of highly detailed investigations succeeded in defining a high-risk subgroup in whom the likelihood of repetition of attempt in the 12 months following a key admission is approximately 50%. This must be compared with a basic rate of 20%, the value for the parasuicide populations as a whole. If then we consider a series of 1000 patients, we might obtain a picture like that in the following table.

OUTCOME OF FIRST-EVER SUICIDAL ATTEMPTS IN PREDICTED HIGH-RISK AND LOW-RISK GROUPS

Prediction	Actual outcome			
	Repeat	No repeat	Total	% repeating
High risk	50	50	100	50
Low risk	150	750	900	17
Total	200	800	1000	20

This table indicates that the predicted high-risk group has a repetition rate approximately three times greater than the low-risk group. However, if preventive action is concentrated on this high-risk subgroup and total success is achieved in preventing repetition, only 50 out of 200 repetitions will have been successfully averted. In terms of value for effort, this may be the best use which can be made of available resources, but nevertheless the outcome is necessarily one of rather limited impact. Of course a more powerful predictive method which would raise the efficiency of the prediction procedure above the 50% mark would yield a better return for each unit of effort invested, but to achieve this it would almost certainly be necessary to define a yet smaller high-risk subgroup. In the example the high-risk group represents only 10% of the total series. Further shrinkage would inevitably counterbalance the gains obtained by higher prediction, while conversely expanding the size of the high-risk group would mean almost certainly reducing the power of the predictive tests.

The general conclusion on this point is that while research must continue to identify the risks of future suicidal attempts, there are reasons for supposing that the application of such findings will lead to only limited practical results in the near future.

Despite this cautious note it is hoped that these rather simplified illustrations will serve to show how badly further research is needed in the study of self-aggressive behaviour. The examples used have tended to be rather epidemiological, but equal urgency exists in the fields of clinical, psychological and sociological studies, to say nothing of the problems of service organization and evaluation.

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ANNEX VII

SOME RESULTS OF THE RESPONSE TO A NATIONAL SURVEY OF SUICIDE AND ATTEMPTED SUICIDE IN THE NETHERLANDS

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1. Introduction

Viewed in a European context, suicide does not occupy as important a place in the Netherlands as in most other countries. According to WHO statistics, in 1970 the Netherlands ranked seventeenth among 26 European countries, with a suicide rate of 8.1 per 100 000 population. Besides the fact that suicide does not form much of a social problem in the Netherlands from the quantitative point of view, the taboo which prevented the subject from being discussed has contributed to the fact that so far little research has been done in this field. However, as a result of the attention paid in recent years to the problem of suicide, especially by the press, television and radio, this taboo is gradually being lifted.

In the research field, the Netherlands Government sponsored the carrying out of a national survey of suicide and attempted suicide in 1970. The survey was carried out from 1 September 1970 to 1 September 1971 by a sociologist and a social psychiatrist of the research department of the Medical Office for Mental Health of the Ministry of Public Health and Environmental Hygiene.

This survey attempted not only to ascertain by means of a questionnaire how many cases of suicide and attempted suicide confront Dutch family doctors every year, but also to establish the social groups to which the suicides belong. In addition, information was collected on the nature and performance of suicidal acts as such. Another objective of the national survey was to find out whether persons who make nonfatal suicidal attempts display the same characteristics as those who complete suicide. Although data available on this point from home and abroad suggest that this is not the case, they are too incomplete to form a sufficient basis for a further sociological typing of the population. One of the purposes of the national suicide survey is to fill this gap.

As the data analysis is not yet complete, no insight can yet be given into the nature of the suicide groups that may be distinguished. On the other hand, data are already available on the numbers of suicides and attempted suicides returned by the various medical bodies and institutions on behalf of the survey. This paper presents a description and explanation of the method of data collection, and some available results.

2. Data collection

In the Netherlands there are no official statistics on attempted suicides. However, official statistics of completed suicides, with a certain number of characteristics, are compiled by the Central Bureau of Statistics. But as these characteristics do not include all those deemed relevant to the national suicide survey and as the suicide data were to be compared with those on attempted suicide, it was thought necessary to collect the research material independently. The advantage of having the survey done by the health authorities instead of a private research agency was that since the survey depended on voluntary participation, the former was more likely to obtain the support of collaborating bodies. An announcement of the survey, with a request for assistance, was made in a letter from the State Secretary of the Ministry. Enclosed was an inquiry card, with the request that it should be returned as soon as the respondent concerned came into contact with a case of either attempted or confirmed suicide during the period 1 September 1970 to 1 September 1971. Since one of the objectives of the survey was to arrive at a typing of possibly different groups of attempted suicide, the definition of the case was left to the respondent concerned. When this card was received by the research department of the Chief Medical Officer of Mental Health, the respondent concerned was sent the necessary data collection sheets and a new inquiry card. A careful record was kept of each such dispatch, so that after some time had elapsed it could be found from which inquirers forms were still to be expected.

3. The respondents

In order to obtain as complete a picture as possible of the number of successful and unsuccessful attempts at suicide in the Netherlands, all the following potential sources of information were used.

3.1 The family doctor, who was regarded as the most important source of information, since in most cases he is the first to be called upon for help at the first signs of injury or sickness. Hospitals were not included, since it is the rule that upon admission and discharge, the patient's doctor is always informed of this, as well as of the patient's condition.

3.2 The psychiatrist, since his patients are known to include a fairly large number of persons with suicidal tendencies who have been referred to him by their family doctors. It was conceivable that during psychiatric treatment the patient might make one or more suicidal attempts which (for the time being) were unknown to the family doctor, but which it was hoped not to omit from the survey.

3.3 Psychiatric institutions and psychiatric university clinics, which were brought into the survey to supply information on those persons who attempted suicide during a stay in such institutions or were admitted because they had already made such an attempt.

3.4 The Municipal Health Services, which relatively frequently give first aid instead of the family doctor - a common practice in the Netherlands, especially in the cities.

3.5 Institutions which do not usually give medical care to civilians in general but which might encounter cases of suicide, such as institutions for mentally disturbed criminals, prisons, remand homes, the army, the University Health Services.

Table 1

SUICIDE AND ATTEMPTED SUICIDE
1 September 1970 to 1 September 1971, BY RESPONDENT

Respondent	Suicide		Attempted suicide	
	Numbers	%	Numbers	%
Family doctor	774	64.0	2049	49.8
Psychiatrist	43	3.6	400	9.7
Psychiatric institution	58	4.8	475	11.5
Municipal Health Service	262	21.7	1086	26.4
Other sources	72	6.0	103	2.5
Total	1209	100.1	4113	99.9

$\chi^2 = 162.60$ df = 4 $P < 0.01$ (significant)

This table shows that the family doctors and the Municipal Health Service were the main sources of information. The family doctor proved to be a less important source for attempted than for completed suicides, the psychiatrist and psychiatric institutions coming more strongly to the fore for attempted suicide than for completed ones; 21% as against 8%.

Table 2

SUICIDE AND ATTEMPTED SUICIDE
1 September 1970 to 1 September 1971 BY SEX AND RESPONDENT

Respondent	Suicide				Attempted suicide			
	Males		Females		Males		Females	
	Nos.	%	Nos.	%	Nos.	%	Nos.	%
Family doctor	468	64.0	306	64.0	684	43.8	1365	53.5
Psychiatrist	20	2.7	23	4.8	134	8.6	266	10.4
Psychiatric institution	35	4.8	23	4.8	193	12.4	282	11.1
Municipal Health Service	157	21.5	105	22.0	479	30.7	607	23.8
Other sources	51	7.0	21	4.4	72	4.6	31	1.2
Total	731	100.0	478	100.0	1562	100.1	2551	100.0

Table 2 shows that both sexes display practically the same pattern for suicide as regards the sources of the data ($\chi^2 = 6.35$, df = 4, $P > .05$; not significant).

For attempted suicide the situation was different ($\chi^2 = 85.71$, df = 4, $P < 0.01$; significant). Family doctors sent more forms for attempted suicide by females than by males, 53.5% compared with 43.8%. However, this difference is largely compensated for by the categories "Municipal Health Service" and "Other sources". The percentage of forms submitted by a psychiatrist or a psychiatric institution is at the same level for males and females.

It may be concluded from the foregoing:

(1) The family doctor and the Municipal Health Service were the chief sources of information as regards both suicides and attempted suicides.

(2) The family doctor was a more important source of information for suicide than for attempted suicide, whereas psychiatrists and psychiatric institutions gave more information on attempted suicides than on completed suicides.

(3) Whereas for completed suicide both sexes show a roughly identical distribution by respondent, for attempted suicide the family doctor is a more important source of information for females than for males.

4. Representative nature of the data

An attempt has been made to determine to what extent those who were asked to cooperate did in fact comply with the request and to what extent the data sheets represent a national picture of the occurrence of suicide and attempted suicide in the Netherlands.

As regards suicide, the survey data have been compared with those from the causes of death statistics of the Central Bureau of Statistics (CBS). For the period surveyed the CBS registered 1051 suicides, compared with 1209 for the national survey, a difference of 158. For these no doubt a different cause of death than suicide was reported to the CBS.

In the field of attempted suicide there are no official statistics. Since the family doctor, psychiatric institution and Municipal Health Service were the most important respondents, the following attempts were made to find out if they had collaborated fully in the survey.

4.1 The family doctor

Towards the end of the survey period a follow-up study was made to get an impression of the family doctor's response. The 4524 Dutch family doctors who were asked to help in the survey were now requested to make a return on the extent of their participation and the number of suicide attempts which may not have been reported; 68% replied. According to this inquiry it appears that about 1000 suicide attempts had not been reported, so it was assumed that the doctors who did not reply to the follow-up enquiry probably failed to report a proportionately equal number of attempts at suicide.

4.2 The Municipal Health Service

All 56 services replied by telephone that they had reported all cases with which they were confronted.

4.3 The psychiatric institutions

The returns on attempted suicides from this source could be checked against data from continuous registration of patients in these institutions carried out by the Medical Office of Mental Health. This enabled a number of forms to be recovered; nevertheless information on some 125 attempted suicides remained unknown to the survey.

As regards the occurrence of suicide and attempted suicide in the Netherlands, the following conclusions can be drawn.

According to the follow-up report, the family doctors failed to report about 1000 attempted suicides, so that in fact they would be confronted with 3000 rather than 2000 annually. The number is approximately equal to that obtained from hospital registrations, according to which about 3000

attempted suicides are estimated to be admitted to general hospitals per year in the Netherlands.

But not all attempted suicides with whom the family doctor is faced are admitted to hospital. According to the survey 20% of attempted suicides, i.e., about 600 cases, stay outside. Hence the figure of 3000 attempted suicides admitted via family doctors is rather too large. On the basis that some of these admissions take place through other channels, such as the Municipal Health Service, and supposing this number was likewise 20%, then the estimate of 3000 attempted suicides known to the family doctors would not be far wrong.

It may therefore be argued that the number of suicides returned as part of the national survey is higher than that derived from the official statistics.

As regards attempted suicide, the degree of completeness is more difficult to establish. Every year some 3000 cases of attempted suicide come to the notice of family doctors, whereas these have in fact reported 2000 to the survey. However, it cannot be determined how many of these 1000 have already been reported by one of the other respondents, such as the Municipal Health Services. Hence the number of attempted suicides known in medical circles during the survey period will have to be limited to an estimate of 4100 to 5000. Of this number, other data are known from the survey on 4113 suicide attempts. It is also likely that other cases, unknown to any medical body, are left out of consideration.

5. Summary

A national survey of suicide and attempted suicide during the period 1 September 1970 to 1 September 1971 provided data on 1209 suicides and 4113 attempted suicides. Through a comparison with the cause-of-death statistics of the CBS an additional 150 suicides were brought to light by the survey. These had probably been reported as deaths due to some other cause. With regard to attempted suicide, a comparison with hospital admissions and a follow-up among family doctors showed that the number of cases with which family doctors are confronted annually should be increased by some 1000. However, it cannot be determined to what extent data on the 1000 have already been received from other sources. The number of forms received for cases of attempted suicide, 4113, must therefore be regarded as a minimum which might be increased by at most 1000. This means 31 to 39 attempted suicides per 100 000 inhabitants per annum, as against 9.2 actual suicides per 100 000.

Finally, in the Netherlands the family doctor proved to be the most important respondent for cases of suicide, successful or not, the Municipal Health Service coming second in importance.

Annex VII

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THE PILOT STUDY ON ATTEMPTED SUICIDES

The study of attempted suicides proposed at the Zagreb meeting was carried out in the following countries and centres:

Country	Centre	Service	
Austria	Vienna	University Psychiatric Clinic	(1) [1]
Finland	Helsinki	University Hospital, Emergency Receiving Ward	(2)
		Hesperia Hospital, Emergency Ward	(3)
France	Lyon	Ed. Herriot Hospital, Medical Emergency Service	(4)
	Paris	Fernand Widal Hospital, Toxicological Clinic	(5)
	Strasbourg	Regional Hospital Service, Psychiatric Service II	(6)
Hungary	Budapest	General Hospital, Poison Detoxication Ward	(7)
		General Hospital, General Traumatology Admission Ward	(8)
Ireland	Dublin	Mater General Hospital	(9)
		Dr Steeven's General Hospital	(10)
		Adelaide, St James and Richmond General Hospitals	(11)
Italy	Milan	University General Hospital, Psychiatric Clinic, Emergency Unit	(12)
Yugoslavia	Belgrade	Infectious Diseases Clinic, Respiratory Reanimation Centre	(13)
		Mental Health Institute	(14)
	Ljubljana	Psychiatric Outpatient Dispensary	(15)
	Zagreb	First-Aid Reception Centre	(16)
	Novi Sad	University Clinic for Nervous and Mental Diseases, Ward for Forensic Psychiatry, Suicidology, Alcoholism and Drug Addiction	(17)

[1] Numbers in parenthesis are used throughout the following tables to refer to the above centres and services.

Annex VIII

In all, 1120 cases of attempted suicide were examined, during the period December 1973 to January 1974, of whom 230 were aged under 20 and 223 in the age-group 20-24 years. All the centres represented in the study had fixed services and the Zagreb service was equipped with ambulances in which resuscitation could be begun.

In all the centres the services were situated in units or wards which formed part of a larger hospital or clinic; most were in general hospitals, the exceptions being the Hesperia Hospital, Helsinki, and the Belgrade Institute for Mental Health, which are psychiatric hospitals. In Vienna the service is in a psychiatric unit forming part of a general hospital. In Budapest resuscitation could be undertaken in a specialized traumatological institute, and in Belgrade in the clinic for infectious diseases.

The advantage of having the attempted suicide service where there is also a psychiatric service available is that psychiatric care can begin while physical care for the effects of the attempt are being carried out. Table 1 shows the availability of resuscitation and of psychiatric care in services in the collaborating centres. Only in Vienna and Dublin were all three types of service provided in the same centre. The periods during which the services were open to clients reflect the dichotomy between the resuscitation and psychiatric units. Where both were in the same place, the attempted suicide services were open for 24 hours a day and 7 days a week. The Belgrade Institute for Mental Health was open to patients for 7 hours a day, on 6 days a week and the Ljubljana Psychiatric Outpatient Dispensary for 12 hours a day on Monday to Friday and for 5 hours on Saturday.

It would be of interest to be able to compare the resources in beds and personnel in relation to the population served, but table 2 shows how difficult it is to obtain satisfactory statistics. In several centres it is not possible to separate the numbers relating to attempted suicides from those available for all types of emergency, nor in the case of psychiatric units to distinguish the time devoted to the suicide attempters from that devoted to other mental patients. The data for the Viennese Centre, where the suicide treatment unit appears to be rather more self-contained than some of the others, show that of a population of just over one and a half million, 27.3% are under the age of 25 years. The average number of beds per psychiatrist is 12. Resuscitation is carried out by the psychiatrists, who on average are each helped by a full-time equivalent of 5.5 nurses and 1.7 social workers.

Table 1

AVAILABILITY OF RESUSCITATION SERVICES AND PSYCHIATRIC CARE IN SERVICES FOR ATTEMPTED SUICIDE

Centre	Resuscitation		Psychiatric care
	Poisoning reversal	Surgical care for cuts, wounds, etc.	
Austria			
Vienna (1)	x	x	x
Finland			
Helsinki (2)	x	x	
(3)	x		x
France			
Lyon (4)	x		x
Paris (5)	x		x
Strasbourg (6)			x
Hungary			
Budapest (7)	x		
(8)		x	
Ireland			
Dublin (9)	x	x	x
(10)	x	x	x
Italy			
Milan (12)			x
Yugoslavia			
Belgrade (13)	x		
(14)			x
Ljubljana (15)			x
Zagreb (16)	x		x
Novi Sad (17)			x

Table 2

POPULATION SERVED. NUMBER OF BEDS AVAILABLE FOR ATTEMPTED SUICIDES AND STAFFING OF SERVICES IN FULL-TIME EQUIVALENTS

Centre	Population served		No. of available beds	Staffing		
	Total	0-24 yrs		Medical	Nursing	Other
Austria Vienna (1)	1 614 841	440 998	144	Psychiatrists 12	Nurses 65	Social workers 2 Minister 1
Finland Helsinki (2)	1 000 000	390 000	32 any emergency	Internist 1 Surgeon 1 Consultants: Psych. ; Anaesth. ; Neurol. ; Pulmol.	Nurses 11-14	X-ray dept. Laboratories
(3)	516 000	183 000	18	Psychiatrist 1 Junior psychiatrist 1	Nurses 9 Mental nurses 5	Charwomen 3.5 Ward asst. 1
France Lyon (4)	1 000 000	-	45	Psychiatrists 6 Toxicologists 2 Internists 4	Nurses 17	Psychologist 1 Social workers 1.5
Paris (5)	10 000 000	-	12 resuscitation 18 psychiatric	Psychiatrist 1.5 Toxicol. intern. resident 1 assistants 5	Nurses 9	Psychologist .5 Social worker 1
Strasbourg (6)	350 000	-	67 all purposes	Psychiatrists 2 Internists 6 Students 16	Nurses and nursing aides 24	
Hungary Budapest (7)	3 000 000 over 15 yrs		150	Toxicologists 3 Internists 3 Psychiatrist 1/8	Nurses 38	Psychologist 1
(8)	2 000 000	-		Surgeons 10	Qualified nurses 50	
Ireland Dublin (9)	200 000	-	as required	Surgeons 10 Physicians 13.3 Psychiatrists 2.7 Junior doctors 30	Nurses 400	Social workers 6
(10)	80 000	-	as required	Surgeons 7 Physicians 8.5 Psychiatrist 1 Junior doctors 16	Nurses 200	Social workers 2 2/3
Italy Milan (12)	1 000 000	400 000	30	Psychiatrists 15 Radiologist 1 Volunteer doctors, part-time 8	-	Laboratory techn. 5
Yugoslavia Belgrade (13)	1 209 361	-	5	Specialist for infect. dis. 4/21	Nurses 4/21	
(14)	1 209 361	-	4	Neuropsych. 6/21	-	Psychologists 6/21 Social workers 4/21
Ljubljana (15)	570 000	236 550	-	Psychiatrists 9	Nurses 4	Psychologists 4 5/42 Clerk 6 5/14
Zagreb (16)	700 000	245 000	6	Intern toxicol. consultant 1 Radiologist 2/21 Neuropsychiatrist 1/21 Specialists in emerg. med. 30	Medical sisters 8	Attendants 40 Drivers 32 Admin. & techn. 100
Novi Sad (17)	-	-	unlimited	Psychiatrists 3	Nurses 5	Psychologists 1 Social worker 1

Other patterns prevail in other centres. For example, in Finland there are 32 beds available for coping with any kind of emergency, staffed by one internist and one surgeon and aided by 11-14 nurses. However, consultants are available as required in psychiatry, neurology, anaesthetics and pulmonary disorders, and an X-ray department and laboratories are also available. The Paris Toxicological Clinic is especially useful because of its expertise in dealing with a wide range of toxic substances, many of which may prove fatal if ingested in sufficient quantities; some of these (especially those used in agriculture) are difficult to detect, and to avoid a fatal outcome must be quickly detected and their effects reversed.

So far as postvention services are concerned, not all centres disposed of the services of a social worker, while others did not have a psychologist. However, the ideal staffing for suicide intervention centres and the type of work to be performed by each category of personnel has yet to be worked out, and could prove a fruitful topic for investigation. For this purpose an activity analysis, where over a given period of time each person records exactly what has been done and how long it has taken, would be of great use.

Table 3 gives details of the sex-age distribution of the sample of suicide attempters, subsumed in percentages.[1] This table shows that, with the exception of the Traumatology Unit in Hungary, females who attempted suicide considerably outnumbered males in the services included in the study. This female excess was most pronounced in the Emergency Service in Lyon and the Psychiatric Clinic in Milan, and corresponds to the generally expressed idea that females outnumber males among attempters, while the reverse is true among completers. Except in Lyon, Belgrade and Novi Sad, a high proportion of the males who made attempts were aged 30 and over, whereas the age-groups under 30 were more highly represented among females, except in Hungary, the Paris Toxicological Centre and Zagreb. While the number of young people in this sample may appear small, it must be remembered that those aged under 20 form 20.5% of the 1120 cases reviewed, and that they represent only a fraction of the total cases treated in the services during the year; this helps to indicate the seriousness of the problem of suicide among young people.

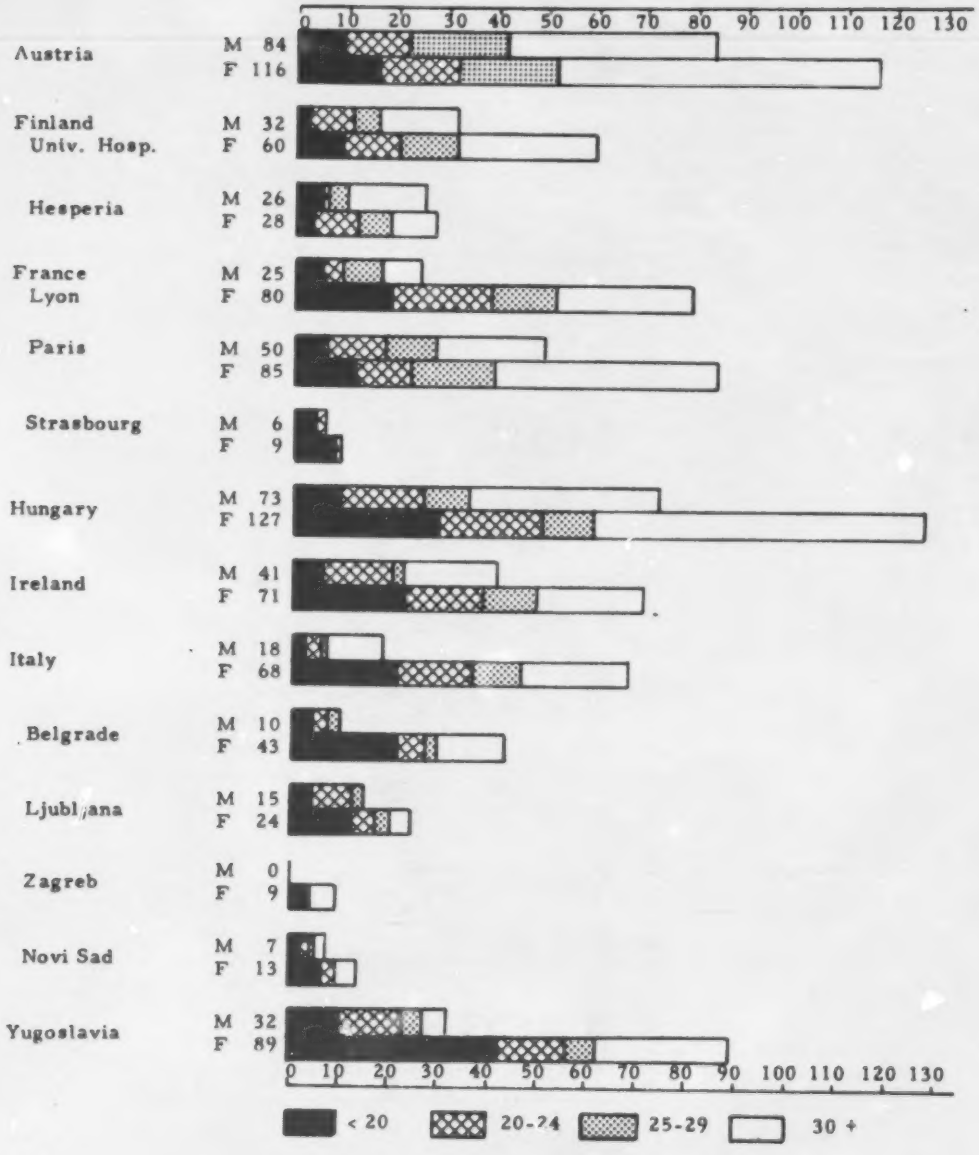
[1] Complete details of the following tables are available, on request, from the WHO Regional Office for Europe.

Table 3

SEX-AGE DISTRIBUTION OF CLIENTS WHO HAD MADE A SUICIDE ATTEMPT

Centre	Sex-ratio ages 0-24 F/M	Males						Females					
		Total	Percentages in age-groups					Total	Percentages in age-groups				
			up to 16	17-19	20-24	25-29	30+		up to 16	17-19	20-24	25-29	30+
Austria													
Vienna (1)	1.4	84	4	7	15	24	50	116	8	6	14	17	55
Finland													
Helsinki (2)	1.9	32	3	3	28	16	50	60	2	13	18	20	47
(3)	1.1	26	4	15	4	15	62	28	4	7	32	25	32
France													
Lyon (4)	3.2	25	-	20	16	32	32	80	6	18	25	16	35
Paris (5)	1.7	50	4	8	24	20	44	85	6	8	13	20	53
Strasbourg (6)	1.5	6	17	50	23	-	-	9	56	33	11	-	-
Hungary													
Budapest (7)	1.8	69	3	9	25	13	50	125	13	10	16	8	53
(8)	.5	4	25	-	-	-	75	2	-	-	50	-	50
Ireland													
Dublin (9)	1.6	16	-	31	25	-	44	26	15	24	15	15	31
(10)	1.5	25	-	4	40	8	48	38	13	18	26	16	27
(11)	-	-	-	-	-	-	-	7	-	-	29	14	57
Italy													
Milan (12)	3.8	18	6	6	22	6	60	68	10	21	22	15	32
Yugoslavia													
Belgrade (13)	2.6	8	12	25	38	-	25	21	33	24	14	-	29
(14)	11.0	2	-	50	-	-	50	22	27	14	14	9	36
Ljubljana (15)	1.6	15	-	27	53	20	-	24	25	25	21	12	17
Zagreb (16)	-	-	-	-	-	-	-	9	-	33	-	11	56
Novi Sad (17)	1.9	7	-	29	29	13	29	13	23	23	23	-	31

1. DISTRIBUTION BY SEX AND AGE



Annex VIII

II. PROPORTION OF SUBJECTS AGED UNDER 20 AND 20-24

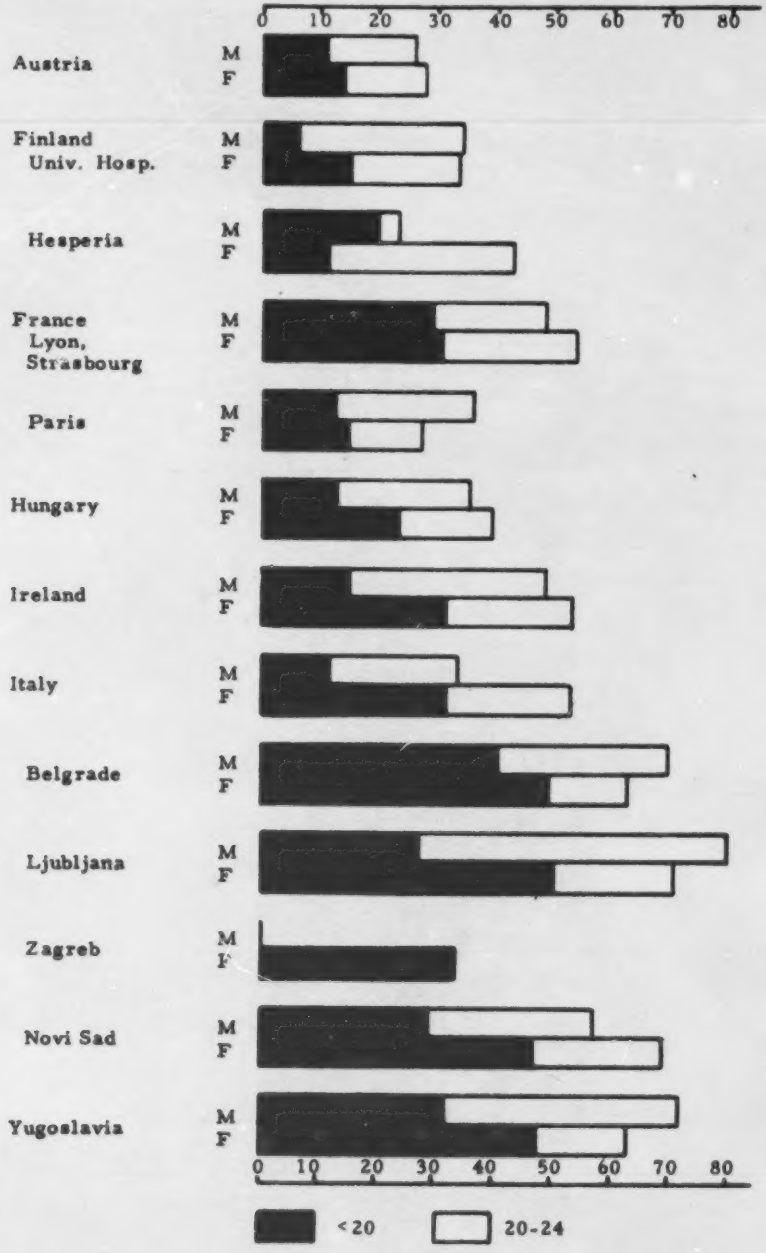


Table 4 shows the distribution of the sample examined by sex, age and civil status. In all centres there was a high proportion of single people, that is of those who had never married; this was especially true of the females. However, single people were also represented in age-groups up to 50 years. In several centres the proportion of single women who were in the age-group under 25 exceeded that for males. It cannot be stated how far these differences are simply representative of the basic population. It is, however, noteworthy that, taken together, the single, widowed, legally separated and divorced outnumbered those who were married or cohabiting. Implicit in this excess is the possibility of social isolation and the lack of a significant caring other person.

Table 5 shows the living status of the clients, according to whether they were living alone, with family, relatives or friends, or in lodgings, hostels, institutions or elsewhere. The proportion of young males under 25 years of age living alone varied from 4% on average in Yugoslavia and 5% in Austria to 19% in Hungary and 20% in Italy, while among young women it varied from 2% in Yugoslavia and 6% in Italy to 22% in Finland and 24% in Paris. Especially in Ireland, Italy and Yugoslavia, the vast majority of those who had attempted suicide were living with family, relatives or friends.

Another of the variables which it was thought desirable to examine in relation to attempted suicide was the clients' employment status. Replies to this question are subsumed in table 6.

As the numbers in each employment status group in the population of the centres are not known, it cannot be decided whether or not those who attempted suicide are proportionately representative of the basic population. General impressions from this table are that female students, especially under age 20, are in excess of what might be expected. The sex-ratio of females to males also is disproportionately high among students. This finding emphasizes what was said during the meeting, that many students, especially in their first year at a university, are very lonely, and that "night-line" services on the campus should be developed, operated by senior students. On the other hand, the number of unemployed at ages 20-24 does not seem to be excessive, but the data were collected before the economic recession in Europe had begun to influence the unemployment figures. It would be interesting to have more up-to-date information to see if it would show higher figures for attempted suicides now that so many school and college leavers are unable to find work.

Table 4

CIVIL STATUS OF CLIENTS WHO HAD MADE A SUICIDE ATTEMPT

Centre	Civil status	Males					Females				
		Total	< 25	25-29	30-49	50+	Total	< 25	25-29	30-49	50+
Austria	Single	37	19	9	9	-	31	22	5	2	2
	Wid; Sep; Div.	17	-	3	10	4	23	2	2	7	12
	Married; Cohab.	30	3	8	14	5	62	8	13	30	11
Finland	Single	24	14	3	7	-	35	22	8	4	1
	Wid; Sep; Div.	9	1	-	6	2	15	2	2	8	3
	Married; Cohab.	25	2	6	16	1	38	8	9	10	11
France	Single	15	10	4	1	-	37	36	1	-	-
Lyon	Wid; Sep; Div.	2	-	1	1	-	10	3	1	4	2
Strasbourg	Married; Cohab.	8	3	2	2	1	37	7	9	18	3
Paris	Single	23	16	4	3	-	24	16	2	5	1
	Wid; Sep; Div.	5	-	2	2	1	8	-	1	6	1
	Married; Cohab.	10	-	3	5	2	36	4	14	15	3
Hungary	Single	17	16	-	1	-	38	30	1	4	3
	Wid; Sep; Div.	7	1	1	4	1	32	5	3	9	15
	Married; Cohab.	48	8	8	20	12	57	15	6	25	11
Ireland	Single	23	16	1	3	3	35	27	4	4	-
	Wid; Sep; Div.	1	-	-	1	-	1	-	-	1	-
	Married; Cohab.	14	4	-	9	1	34	10	7	14	3
Italy	Single	6	5	-	1	-	36	29	2	5	-
	Wid; Sep; Div.	3	-	-	3	-	5	-	1	4	-
	Married; Cohab.	8	1	1	5	1	25	7	7	7	4
Yugoslavia	Single	22	20	2	-	-	52	50	1	1	-
	Wid; Sep; Div.	1	-	1	-	-	5	1	2	2	-
	Married; Cohab.	9	3	1	3	2	32	5	6	16	5

Table 5

PERCENTAGES OF CLIENTS IN EACH AGE-GROUP ACCORDING TO SITUATIONAL STATUS

Centre	Living status	Males					Females				
		Total	< 25	25-29	30-49	50+	Total	< 25	25-29	30-49	50+
Austria	A	21	5	20	32	22	22	17	15	15	48
	F	59	66	65	45	78	74	80	80	80	52
	L	20	29	15	23	-	4	3	5	5	-
Finland	A	16	12	11	19	33	24	22	26	23	27
	F	75	76	78	77	34	69	69	63	77	67
	L	9	12	11	4	33	7	11	11	-	6
France											
Lyon	A	20	15	29	25	-	7	7	9	5	20
Strasbourg	F	64	62	57	75	100	91	89	91	95	80
	L	16	23	14	-	-	2	4	-	-	-
Paris	A	15	13	22	17	-	17	24	12	13	20
	F	68	74	67	58	100	80	71	82	87	80
	L	17	13	11	25	-	3	5	6	-	-
Hungary	A	14	19	-	14	17	13	11	18	12	18
	F	77	74	90	72	83	85	87	73	88	82
	L	9	7	10	14	-	2	2	9	-	-
Ireland	A	6	-	-	8	25	-	-	-	-	-
	F	91	95	100	92	75	97	100	91	95	100
	L	3	5	-	-	-	3	-	9	5	-
Italy	A	24	20	-	33	-	14	6	10	37	-
	F	70	80	100	56	100	81	86	90	63	100
	L	6	-	-	11	-	5	8	-	-	-
Yugoslavia	A	3	4	-	-	-	8	2	20	14	17
	F	90	87	100	100	100	90	94	80	86	83
	L	7	9	-	-	-	2	6	-	-	-

A = Living alone F = Living with family, relatives or friends L = Living in lodgings, hostel, institution or other

III. ISOLATION: PROPORTIONS NOT LIVING WITH FAMILY OR FRIENDS

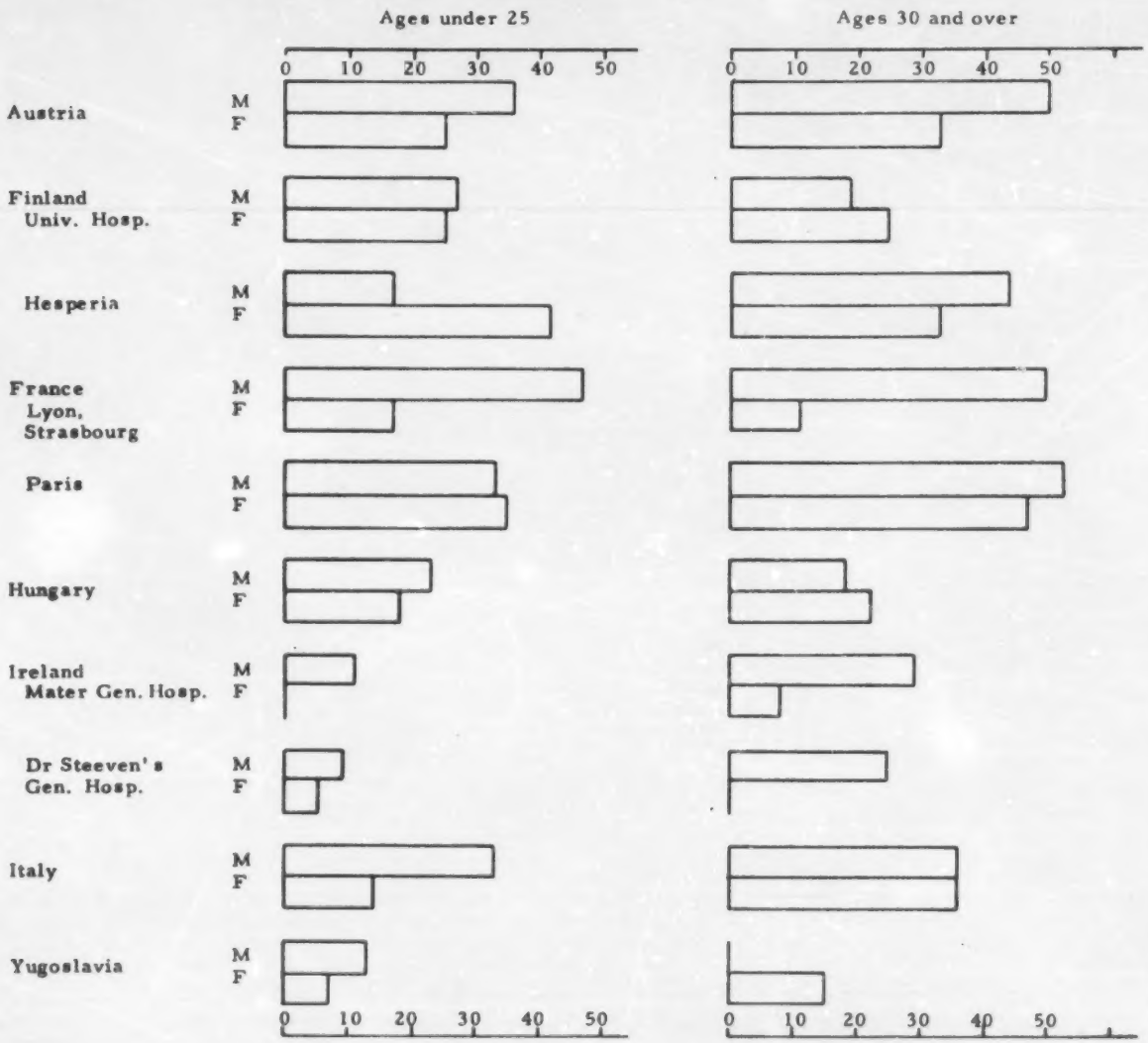
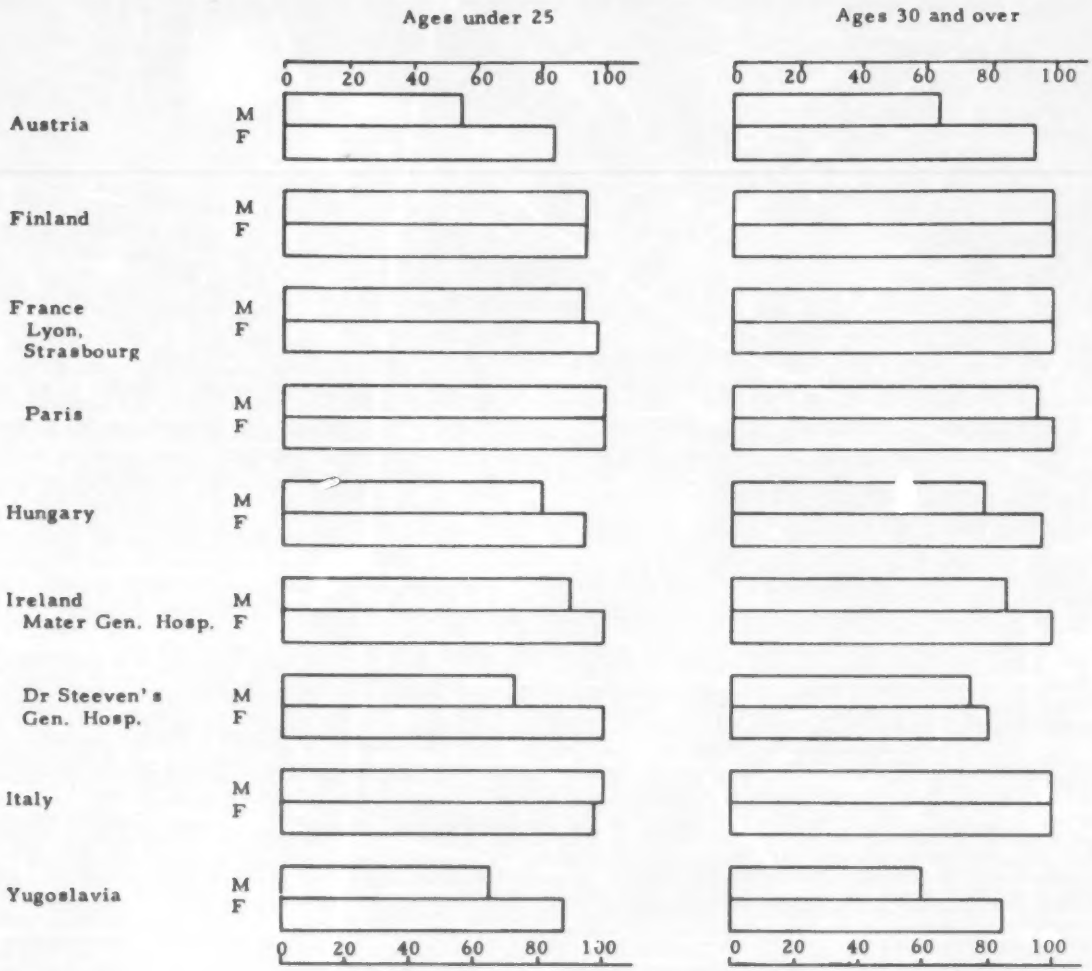


Table 6

EMPLOYMENT STATUS OF CLIENTS WHO HAD MADE A SUICIDE ATTEMPT

Employment status	Centre	Males					Females				
		Total	< 20	20-24	25-49	50+	Total	< 20	20-24	25-49	50+
Retired; unemployed	Austria	24	-	3	15	6	21	2	1	4	14
	Finland	22	2	4	15	1	19	3	4	7	5
	France	15	1	2	10	2	36	5	4	17	10
	Hungary	12	-	1	2	9	19	-	-	2	17
	Ireland	17	1	3	10	3	14	7	4	3	-
	Italy	17	2	3	10	2	32	10	7	15	-
	Yugoslavia	3	1	1	1	-	10	2	3	3	2
Students	Austria	3	1	1	1	-	10	2	3	3	2
	Finland	6	2	2	2	-	14	4	5	5	-
	France	10	5	3	2	-	25	18	7	-	-
	Hungary	3	3	-	-	-	14	14	-	-	-
	Ireland	1	1	-	-	-	6	6	-	-	-
	Italy	-	-	-	-	-	9	7	2	-	-
	Yugoslavia	6	4	-	2	-	35	31	4	-	-
Employed	Austria	53	16	13	21	3	58	17	15	21	5
	Finland	26	7	5	12	2	36	12	9	12	3
	France	47	19	10	18	2	79	30	21	26	2
	Hungary	56	19	9	23	5	86	33	8	34	11
	Ireland	16	11	1	3	1	18	9	3	5	1
	Italy	15	5	1	8	1	32	17	5	10	-
	Yugoslavia	21	16	2	2	1	31	13	4	14	-
Housework only	Austria						24	2	3	13	6
	Finland						18	4	3	4	7
	France						15	2	3	10	-
	Hungary						6	2	1	2	1
	Ireland						27	8	6	11	2
	Italy						22	10	4	5	3
	Yugoslavia						13	3	1	5	4

IV. METHOD: PROPORTION WHO USED POISON



Data on the method used in attempting suicide are grouped in table 7 under three main headings:

Poisoning; by solids, liquids or gases.

Passive Active Methods; hanging and strangulation; drowning; jumping from heights or from moving trains, etc.

Active Active Methods; firearms and explosives; cutting and piercing instruments.

The reason for distinguishing the last two groups is that while they involve to a certain extent an active search for a suitable place, the third group involves a more active effort to procure a firearm, for example, and learn how to use it, and to know where to inflict a wound so that it may be fatal.

Table 7 shows that the overwhelming majority of suicide attempters in this enquiry used poisoning, and among the latter very few used gases. Especially among the females, in each of the age-groups shown at least 95% of all attempters had used poisons. None of the attempters from Finland, Italy and Ireland used hanging, drowning, etc. This method was chiefly used by Austria, Hungary and Yugoslavia. These three countries, together with Ireland, accounted for practically all the attempts by shooting, cutting and piercing. Both "active" categories contributed higher proportions to the total males in age-groups 20-24 and 25-29, whereas those under 20 years of age and 30 years and over tended more to the use of poisons.

The degree of consciousness of clients at admission to the service may depend upon the seriousness of the attempt and the time before resuscitation was begun. It is generally agreed that many people do not know what quantity of a poison constitutes a lethal dose. In the present study only three people who used gases were unconscious at admission; all three were in the age-group 25 and over. Two males were admitted to the services in Ireland and Italy respectively, and one female to that in Hungary. For the young people aged under 25 with which the study is primarily concerned, the total number in each centre and the percentages who, on admission, were completely or partly conscious or unconscious, are shown in table 8.

Table 8 shows also that, on the average, about one-fifth of the young men who attempted suicide by poisoning were unconscious on arrival at the receiving services, while for young women the proportion was between one-eighth and one-ninth. Higher proportions might have been expected in Austria, France and Hungary, where the services were primarily for reanimation. In France, the proportion of females who were unconscious was 23%, nearly twice the average. However, more than half the young women attempters were completely conscious at admission, compared with 43% of the young men. Of those who employed active violent methods more than three-quarters of the males and all but 1 of 22 females were

Table 7

NUMBERS AND PERCENTAGES OF PEOPLE IN EACH AGE-GROUP ACCORDING TO THE TYPE OF METHOD USED FOR ATTEMPTING SUICIDE

Method of attempting suicide	Centre	Males					Females				
		Total	< 20	20-24	25-29	30+	Total	< 20	20-24	25-29	30+
Poisoning	Austria	48	8	4	9	27	108	15	12	20	61
	Finland	57	7	9	9	32	86	11	19	19	37
	France	78	14	18	17	29	173	39	31	30	73
	Hungary	60	8	13	9	30	121	27	20	9	65
	Ireland	33	5	11	2	15	68	22	16	10	20
	Italy	18	2	4	1	11	67	20	15	10	22
	Yugoslavia	21	8	7	3	3	78	36	13	6	23
	Total	315	52	66	50	147	701	170	126	104	301
	%	82	91	74	79	84	96	95	95	98	97
Passive Active	Austria	14	1	4	3	6	2	-	1	-	1
	Finland	-	-	-	-	-	-	-	-	-	-
	France	2	-	-	1	1	1	-	1	-	-
	Hungary	4	1	2	-	1	3	-	1	-	2
	Ireland	-	-	-	-	-	-	-	-	-	-
	Italy	-	-	-	-	-	-	-	-	-	-
	Yugoslavia	5	-	2	1	2	4	2	1	-	1
	Total	25	2	8	5	10	10	2	4	-	4
	%	7	4	9	8	6	1	1	3	0	1
Active Active	Austria	21	-	5	8	8	6	1	3	-	2
	Finland	1	-	1	-	-	1	1	-	-	-
	France	1	1	-	-	-	-	-	-	-	-
	Hungary	7	-	2	-	5	3	2	-	1	-
	Ireland	7	-	3	-	4	3	-	-	1	2
	Italy	-	-	-	-	-	1	1	-	-	-
	Yugoslavia	6	2	4	-	-	5	3	-	-	2
	Total	43	3	15	8	17	19	8	3	2	6
	%	11	5	17	13	10	3	4	2	2	2
Total	All centres	383	57	89	63	174	730	180	133	106	311
	%	100	100	100	100	100	100	100	100	100	100

completely conscious. This may reflect the fact that with the more violent methods of attempt there is less possibility of a middle state between failing and succeeding to commit suicide.

Table 8

DEGREE OF CONSCIOUSNESS AT ADMISSION OF CLIENTS AGED UNDER 25 YEARS WHO USED POISONING BY SOLIDS OR LIQUIDS AND "ACTIVE" METHODS

Method used	Centre	Males				Females			
		Total	CC	PC	UC	Total	CC	PC	UC
Poisoning by liquids or solids	Austria	12	4	6	2	27	9	14	4
	Finland	16	6	8	2	29	7	18	4
	France	31	14	10	7	69	41	12	16
	Hungary	21	8	9	4	49	22	22	5
	Ireland	16	10	1	5	37	32	3	2
	Italy	6	1	4	1	33	25	8	-
	Yugoslavia	15	8	5	2	51	25	21	5
	Total	117	51	43	23	295	161	98	36
	%	100	43	37	20	100	55	33	12
"Active" methods	Austria	10	10	-	-	5	5	-	-
	Finland	1	1	-	-	2	2	-	-
	France	1	1	-	-	1	1	-	-
	Hungary	5	2	3	-	4	3	1	-
	Ireland	4	3	1	-	1	1	-	-
	Italy	-	-	-	-	1	1	-	-
	Yugoslavia	8	6	-	2	8	8	-	-
	Total	29	23	4	2	22	21	1	-
	%	100	79	14	7	100	96	4	-

CC = completely conscious PC = partly conscious UC = unconscious

It was pointed out by several speakers and demonstrated by the work done in Vienna that suicidal attempts are often made when people have ingested alcohol or drugs, and that the prognosis for repeating the attempt is worse where both have been consumed. However, the data obtained are of limited value owing to the large number of "not knowns".

Table 9 shows that the pattern of referral varied considerably between the centres. This pattern will of course be influenced by the organization of the services, so that if suicide attempters are first taken to a surgical or resusciation department and the service participating in the study is a psychiatric unit to which patients are later transferred, there will in these centres be a larger proportion who are admitted from the surgical or resuscitation units. In Hungary, the person's own doctor was the source of referral for 76% of males and 86% of females.

Table 9

SOURCE OF REFERRAL TO THE SUICIDE SERVICES, BY SEX, NUMBERS AND PERCENTAGES

Referral procedure	Austria		Finland		France		Hungary		Ireland		Italy		Yugoslavia	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
							Males							
Sent by own doctor	6	7	3	5	12	15	56	76	2	5	-	-	5	16
Brought by police	17	20	4	7	29	35	4	6	5	12	1	6	2	6
Brought by relatives	7	8	27	47	15	19	2	3	19	46	9	50	9	28
Brought by spec. suic. services	3	4	-	-	1	1	4	6	-	-	-	-	-	-
Referred by general hospital:														
surgical dept.	14	17	2	3	6	7	1	1	-	-	1	6	6	19
resuscitation dept.	2	2	2	3	2	3	-	-	-	-	1	6	6	19
Came by himself	6	7	8	14	2	3	1	1	6	15	2	11	1	3
Other	29	35	12	21	14	17	5	7	9	22	4	21	3	9
Total	84	100	58	100	81	100	73	100	41	100	18	100	32	100
							Females							
Sent by own doctor	6	5	7	8	34	20	110	86	6	9	1	2	16	18
Brought by police	14	12	7	8	51	29	-	-	5	7	1	2	-	-
Brought by relatives	14	12	53	60	52	30	3	2	37	52	36	52	32	36
Brought by spec. suic. services	64	55	1	1	1	1	2	2	-	-	-	-	-	-
Referred by general hospital:														
surgical dept.	6	5	-	-	10	6	1	1	-	-	3	4	3	3
resuscitation dept.	7	6	-	-	6	3	-	-	-	-	1	2	26	30
Came by herself	3	3	5	6	2	1	1	1	17	23	1	2	1	1
Other	2	2	15	17	18	10	10	8	6	9	25	36	11	12
Total	116	100	88	100	174	100	127	100	71	100	68	100	89	100

By comparison, in Italy the proportions sent by their own doctors were negligible. The police were the chief source of referral for males and the second highest for women in France, 35% and 29% respectively; and these proportions were also the highest for all centres. In Finland, Ireland, Italy and Yugoslavia, the clients were most frequently brought by relatives who played an insignificant part in Hungary. Relatively few clients were brought by special suicide services except Austrian females, more than half of whom came from this source. What is perhaps surprising is that in this sample 26 males and 30 females came of their own accord to the services, suggesting that the attempt was regretted almost as soon as it was made.

The question of whether the person who attempts suicide is visited by a significant other is important, since often the two can be cared for simultaneously by the psychiatrist and social worker with a view to remedying the situation which led to the suicidal attempt. Since such a high proportion of the study sample were living with families, relatives or friends, it might be expected that the majority did, in fact, have at hand someone who could be regarded as a significant other. Table 10 shows whether or not a significant other came to visit the one who attempted suicide and at what interval after the attempt.

Table 10 shows that the proportion of male attempters visited during the day of admission or the first week afterwards varied between the centres and was particularly low in Austria, average 23%, and high in Italy, 78%. But in Austria on average 72% of female attempters were visited, the same proportion as in the Italian centre. Of those under 25 years in the Austrian centre, 63% were visited, compared with 75% in Milan. In Finland, the proportions visited were the second lowest of all centres for males and the lowest for females; the proportions of clients in the under-25-years age-group who were visited were only 41% and 38% for males and females respectively. In the French centres of Lyon and Strasbourg, 61% of males and 72% of females were visited, and for both males and females the age-groups 30 and over were most frequently visited. In the Paris centre, although 62% of males were visited and in particular 67% of those aged under 25 years, only 48% of females on average and 57% aged under 25 years received visits.

In the Hungarian centres just over half were visited and there was little variation among the age-groups for each sex. Ireland also had percentages relatively steady across the age-groups, and on average proportions exceeding 60% were visited. The Italian averages were high and in particular 75% of young women were visited. In the Yugoslav centres, higher proportions of females were visited and, at ages under 25, 77% of the females, the highest proportion for all centres.

In searching for explanations of these variations, one reason may be the distance of family, friends and others. Certainly in Paris the number of students, not only from the rest of France but from overseas, is high. The distance from home, coupled with conditions of life in large metropolitan centres, may not only help to account for the numbers who

attempt suicide but also for the fact that some are not visited by a significant other. In smaller provincial universities, students, especially female ones, may not be at such high risk.

While it is generally agreed to be desirable, and in some countries it is even statutory, that people who have attempted suicide should be seen by a psychiatrist, the extent to which this is done will depend on the type of service studied and the staff available. Units such as the Toxicological Clinic in Paris, the Lyon Emergency Service, the Hungarian centres, the Belgrade Reanimation Centre and the Zagreb emergency service, which are primarily devoted to the reversal of the effects of the suicidal attempt, had relatively high proportions of clients who did not see a psychiatrist while they were in that particular service. This was true also for the University Hospital in Helsinki, where psychiatrists acted as consultants and not as regular staff members. The proportions of young people aged under 25 who did not see a psychiatrist, were as follows:

		Males (%)	Females (%)
Finland	(2)	9	20
	(3)	17	8
France	Lyon (4)	22	10
	Paris (5)	18	39
	Strasbourg (6)	17	0
Hungary	(7)	72	96
	(8)	100	100
Ireland	(10)	46	100
	(11)	no cases	50
Yugoslavia	Belgrade (13)	33	33
	Zagreb (16)	no cases	100
	Novi Sad (17)	50	22

Table 8 showed the relatively high proportions of clients who were completely conscious at admission and the correspondingly low proportions who were unconscious. The proportions may be expected to influence the distribution of clients by length of stay. From all centres together, only 15 males and 20 females stayed 21 days or more in the service to which admitted.

Table 11 shows the distribution of clients by the time between admission and discharge; those who stayed 21 days or more are excluded from the table. For the centres which took part in the study, those which gave a reanimation service seem to keep the clients for longer periods. However, if the patients were transferred elsewhere for psychiatric care, a shorter length of stay might be observed.

Table 10

WHETHER AND WHEN A SIGNIFICANT OTHER CAME TO VISIT THE CLIENT

Centre	Visit of significant other	Males				Females			
		Total	<25	25-29	30+	Total	<25	25-29	30+
Austria	Day of admn	3	1	1	1	67	16	11	40
	1-7 days	16	4	3	9	17	4	5	8
	None came	52	15	11	26	18	8	1	9
	Not known	13	2	5	6	14	4	3	7
	% visited	23	23	20	24	72	63	80	75
Finland	Day of admn	12	5	2	5	19	7	7	5
	1-7 days	10	2	2	6	19	5	3	11
	None came	28	9	3	16	33	14	5	14
	Not known	8	1	2	5	17	6	4	7
	% visited	38	41	44	34	43	38	53	43
France Lyon and Strasbourg	Day of admn	17	8	3	6	63	34	6	23
	1-7 days	2	1	1	-	1	-	1	-
	None came	4	4	-	-	11	11	-	-
	Not known	8	2	4	2	14	3	6	5
	% visited	61	60	50	75	72	71	54	82
Paris	Day of admn	2	1	1	-	5	2	1	2
	1-7 days	29	11	5	13	36	11	10	15
	None came	12	2	4	6	22	6	3	13
	Not known	7	4	-	3	22	4	3	15
	% visited	62	67	60	59	48	57	65	38
Hungary	Day of admn	17	6	1	10	21	11	3	7
	1-7 days	21	7	3	11	47	14	3	30
	None came	32	12	4	16	51	24	4	23
	Not known	3	1	1	1	8	1	-	7
	% visited	52	50	44	55	54	50	60	55
Ireland	Day of admn	14	8	1	5	35	20	8	7
	1-7 days	11	5	-	6	11	6	-	5
	None came	9	5	-	4	19	8	1	10
	Not known	7	2	1	4	6	4	2	-
	% visited	61	65	50	58	65	68	73	55
Italy	Day of admn	10	3	1	6	31	18	4	9
	1-7 days	4	1	-	3	18	9	4	5
	None came	2	1	-	1	1	1	-	-
	Not known	2	1	-	1	18	8	2	8
	% visited	78	67	100	82	72	75	80	64
Yugoslavia	Day of admn	13	8	2	3	42	27	2	13
	1-7 days	5	4	-	1	19	16	1	2
	None came	13	10	2	1	11	4	2	5
	Not known	1	1	-	-	17	9	1	7
	% visited	56	52	50	80	69	77	50	56

Annex VIII

V. PROPORTION FOR WHOM NO SIGNIFICANT OTHER CAME

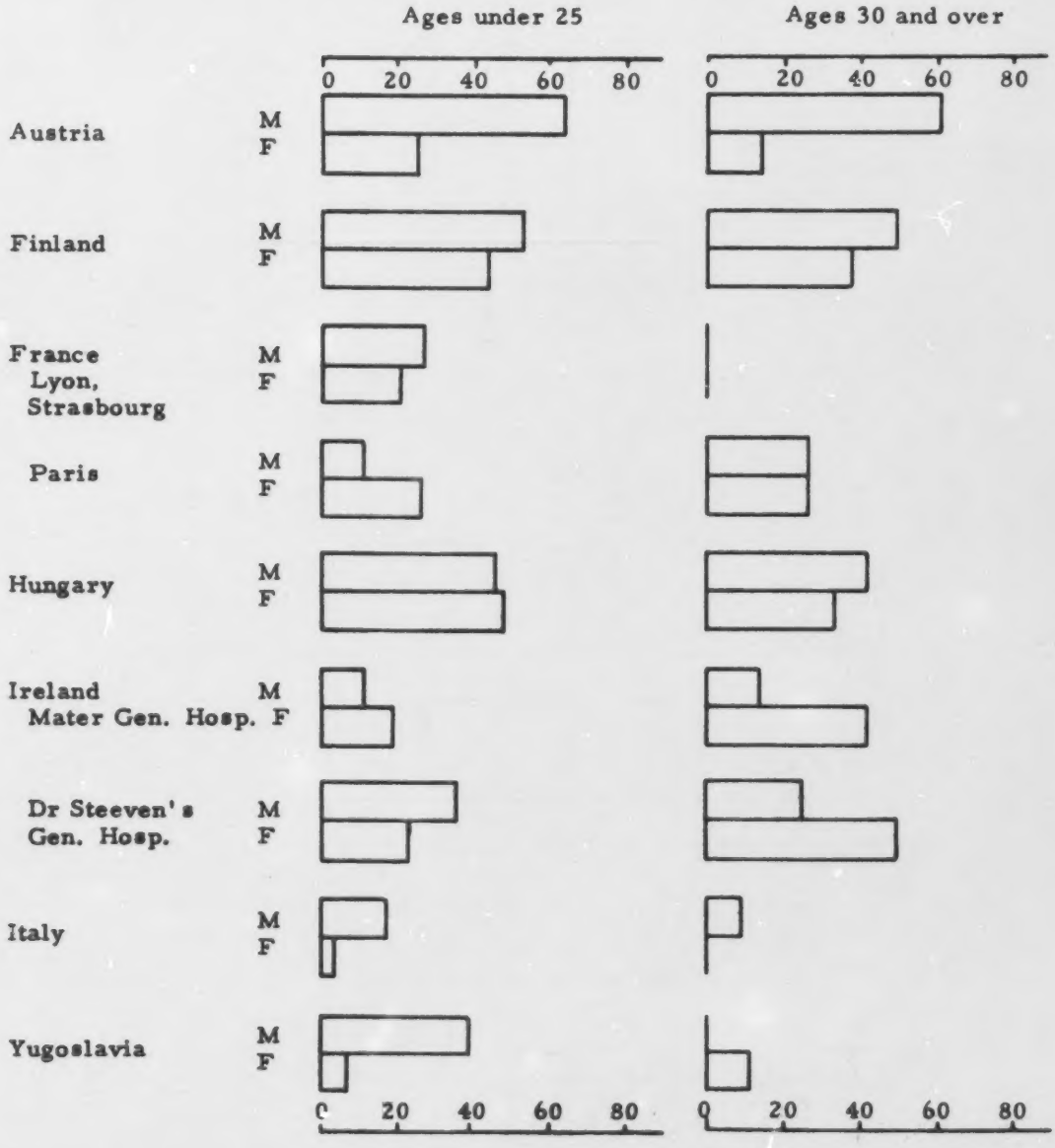


Table 11

PERIOD IN DAYS BETWEEN ADMISSION TO, AND DISCHARGE FROM, THE SERVICE, FOR THOSE WHO STAYED LESS THAN 21 DAYS

Centre	Age-group	Males					Females				
		Total	Same or next day	2-6 days	7-13 days	14-20 days	Total	Same or next day	2-6 days	7-13 days	14-20 days
Austria	< 25	21	11	7	2	1	32	20	7	5	-
	25-29	20	11	8	1	-	20	12	6	2	-
	30+	42	21	18	1	2	63	37	17	9	-
Finland	< 25	17	12	5	-	-	32	22	10	-	-
	25-29	9	7	1	1	-	19	15	3	1	-
	30+	32	18	13	1	-	37	26	9	2	-
France:	< 25	14	8	5	1	-	48	24	18	5	1
Lyon &	25-29	8	3	2	3	-	13	8	5	-	-
Strasbourg	30+	8	6	2	-	-	28	11	14	3	-
Paris	< 25	16	3	6	5	2	21	4	8	7	2
	25-29	9	-	4	2	3	15	1	7	5	4
	30+	19	2	13	4	-	42	10	16	8	8
Hungary	< 25	26	16	9	-	1	49	28	21	-	-
	25-29	9	5	3	-	-	9	8	1	-	-
	30+	38	17	15	4	2	66	30	30	6	-
Ireland	< 25	20	8	11	-	1	37	14	23	-	-
	25-29	2	-	2	-	-	11	4	6	-	1
	30+	19	8	11	-	-	21	7	12	1	1
Italy	< 25	5	-	1	2	2	36	6	16	9	5
	25-29	-	-	-	-	-	10	3	6	1	-
	30+	10	-	3	5	2	21	7	5	5	4
Yugoslavia	< 25	8	-	6	2	-	25	1	16	5	3
	25-29	-	-	-	-	-	1	-	-	1	-
	30+	4	-	2	1	1	14	-	9	4	1

Annex VIII

It is useful to know where the clients treated in the centres went to when they left. Of the whole sample of 1120 cases, only 3 males and 4 females died; of these, 2 males and 3 females were aged 30 and over, and 1 male and 1 female were aged under 25 years. Excluding those who died, the numbers who were transferred to psychiatric care, to special after-care units or general hospitals, to private practitioners or simply back to the community, are shown in table 12.

Table 12 also shows that in the Austrian centre the majority of patients on leaving were referred to psychiatric care and in fact 68 males and 80 females were transferred as inpatients. In Finland, male clients were more evenly divided between psychiatric care and a return to the community. Nineteen males and 27 females were discharged to inpatient psychiatric care, compared with 10 males and 19 females who sere sent to outpatient services. The French centres sent the highest proportions of males and females to special after-care units or to general hospitals. Relatively few were discharged to psychiatric care, the majority being returned to the community; the latter finding was particularly striking in the Paris toxicological clinic. The Hungarian clients were also largely sent to the community; 58 males and 104 females out of totals of 71 and 127 respectively. The Irish clients were most frequently discharged to psychiatric care: for males 15 to inpatient and 20 to outpatient services and for females 13 to inpatient and 48 to outpatient care. In Milan the majority were discharged to psychiatric outpatient services, while in Yugoslavia the emphasis was chiefly on psychiatric care for men and roughly divided between psychiatric care and a return to the community for women.

It is striking that so few of those who had made suicidal attempts were discharged to the care of their private practitioners.

From the viewpoint of those who are organizing voluntary agencies to help people with their problems, especially agencies which hope to attract as clients people who might be tempted to commit suicide, for example the Samaritans or La Main Tendue, it is desirable to know whether they are in fact attracting the clientele desired. It might also be expected that those who had made a previous attempt would have been alerted to the help they might have received, so that if in difficulty a second time they would perhaps be more likely to use the voluntary service. Table 13 shows how many of those who had previously made an attempt did contact a caring service before making the present one. For example of 84 males admitted to the Vienna clinic, 20 had made a previous attempt, and of these 20, 1 man contacted the voluntary agency before making the present attempt; 56 had not made a previous attempt and none of these contacted a helping agency before the attempt. For 8, either it was not known whether they had been hospitalized before, or not known whether they contacted a helping agency, or both items were not known. It appears that only two males were known to have contacted a voluntary service, compared with nine women. Unfortunately there is no way of knowing how many more people might have had to be admitted to the services taking part in the study had it not been for the work of the prevention agencies.

Table 12

DISPOSAL OF PATIENTS AT DISCHARGE, BY SEX AND AGE

Centre	Disposal at discharge	Males				Females			
		Total	< 25	25-29	30+	Total	< 25	25-29	30+
Austria	Psych. hosp. or OP	71	18	17	36	84	19	14	51
	Spec. unit or gen. h.	3	1	-	2	3	1	1	1
	Private practice	-	-	-	-	-	-	-	-
	Community	10	3	3	4	27	12	5	10
Finland	Psych. hosp. or OP	29	9	5	15	46	19	7	20
	Spec. unit or gen. h.	3	-	1	2	15	6	3	6
	Private practice	1	-	-	1	9	2	5	2
	Community	24	8	3	13	18	5	4	9
France	Psych. hosp. or OP	11	6	4	1	22	14	2	6
Lyon &	Spec. unit or gen. h.	3	3	-	-	5	1	2	2
Strasbourg	Private practice	3	-	1	2	5	1	1	3
	Community	14	6	3	5	57	32	8	17
Paris	Psych. hosp. or OP	6	2	2	2	13	3	-	10
	Spec. unit or gen. h.	8	4	-	4	16	1	1	14
	Private practice	2	2	-	-	2	1	1	-
	Community	33	10	8	15	53	17	15	21
Hungary	Psych. hosp. or OP	11	5	1	5	20	6	1	13
	Spec. unit or gen. h.	1	-	-	1	3	-	-	3
	Private practice	1	-	-	1	-	-	-	-
	Community	58	20	8	30	104	44	9	51
Ireland	Psych. hosp. or OP	35	16	2	17	61	32	9	20
	Spec. unit or gen. h.	1	1	-	-	1	1	-	-
	Private practice	3	2	-	1	3	2	-	1
	Community	2	1	-	1	6	3	2	1
Italy	Psych. hosp. or OP	10	4	1	5	42	23	4	15
	Spec. unit or gen. h.	2	1	-	1	-	-	-	-
	Private practice	1	-	-	1	7	3	3	1
	Community	5	1	-	4	19	10	3	6
Yugoslavia	Psych. hosp. or OP	21	12	4	5	38	22	5	11
	Spec. unit or gen. h.	2	2	-	-	7	5	1	1
	Private practice	1	1	-	-	2	2	-	-
	Community	8	8	-	-	39	26	-	13

Table 13

WHETHER THE CLIENT HAD HAD PREVIOUS HOSPITAL TREATMENT FOR ATTEMPTED SUICIDE BY WHETHER HE HAD CONTACTED A VOLUNTARY ORGANIZATION BEFORE THIS ATTEMPT

Centre	Previous attempt (PA)	Males								Females							
		Total		< 25		25-29		30+		Total		< 25		25-29		30+	
Austria	PA contacted	1	20	0	6	1	3	0	11	0	23	0	7	0	5	0	11
	No PA or not contacted	0	56	0	15	0	10	0	25	0	89	0	22	0	15	0	52
	Not known		8		1		1		6		4		3		-		1
Finland	PA contacted	0	24	0	3	0	5	0	16	1	37	0	15	1	8	0	14
	No PA or not contacted	1	31	0	13	0	4	1	14	1	46	0	15	1	9	0	22
	Not known		3		1		-		2		5		2		2		1
France	PA contacted	0	22	0	10	0	4	0	8	0	46	0	17	0	8	0	21
	No PA or not contacted	0	33	0	12	0	8	0	13	1	70	0	29	0	12	1	29
	Not known		26		11		6		9		58		25		10		23
Hungary	PA contacted	0	15	0	6	0	1	0	8	0	30	0	11	0	3	0	16
	No PA or not contacted	0	57	0	20	0	8	0	29	1	85	0	38	0	7	1	40
	Not known		1		-		-		1		12		1		-		11
Ireland	PA contacted	0	13	0	8	0	0	0	5	0	20	0	7	0	2	0	11
	No PA or not contacted	0	14	0	8	0	0	0	6	1	34	1	24	0	6	0	4
	Not known		14		4		2		8		17		7		3		7
Italy	PA contacted	0	5	0	1	0	0	0	4	2	12	1	8	1	1	0	3
	No PA or not contacted	0	13	0	5	0	1	0	7	2	52	1	28	1	8	0	16
	Not known		-		-		-		-		4		-		1		3
Yugoslavia	PA contacted	0	6	0	4	0	0	0	2	0	12	0	6	0	2	0	4
	No PA or not contacted	0	22	0	16	0	4	0	2	0	64	0	45	0	3	0	16
	Not known		4		3		-		1		13		5		1		7

It may be that their effect is to deter people from attempting suicide and that is why the numbers included in the study who had made a contact are so small.

The view of attempted suicide as a "cry for help" in a difficult situation has led to the question of who is the best person to recognize the need for assistance and to act upon it before the person in difficulties gets to the stage of taking suicidal action. It is suggested that one such person might be the client's general (family) doctor, and that contact might be made on the pretext of consulting for a minor illness. The question that arises is to what extent the doctor might recognize the underlying problem and decide to take some early action. The question was therefore asked in this study, whether the patient had consulted his own doctor in the two weeks before the attempt. The results are shown in table 14.

Table 14

WHETHER THE CLIENT HAD CONSULTED HIS OWN DOCTOR IN THE TWO WEEKS BEFORE THE ATTEMPT OR NOT

Centre	Whether doctor consulted	Males				Females			
		Total	<25	25-29	30+	Total	<25	25-29	30+
Austria	Yes	4	9	-	2	21	13	10	28
	No	86	86	90	86	69	81	80	61
	Not known	10	5	10	12	10	6	10	11
Finland	Yes	38	35	22	18	35	41	21	38
	No	57	59	78	73	56	50	74	51
	Not known	5	6	-	9	9	9	5	11
France	Yes	22	33	6	20	20	20	30	16
	No	48	43	50	53	44	45	43	44
	Not known	30	24	44	27	36	35	27	40
Hungary	Yes	43	46	22	46	34	42	10	31
	No	56	54	78	51	58	56	90	56
	Not known	1	-	-	3	8	2	-	13
Ireland	Yes	37	45	-	32	52	40	46	77
	No	53	55	-	57	45	57	54	18
	Not known	10	-	100	11	3	3	-	5
Italy	Yes	22	17	-	27	10	6	40	5
	No	78	83	100	73	86	94	60	81
	Not known	-	-	-	-	4	-	-	14
Yugoslavia	Yes	22	26	-	20	20	11	50	33
	No	62	57	100	60	60	68	33	48
	Not known	16	17	-	20	20	21	17	19

Table 14 shows that the proportion of people attempting suicide who had visited their doctor within the two weeks before the attempt was far from insignificant. Unfortunately there are no statistics available from which it could be established whether there was a significant difference in the proportions of attempters compared with those of the same age in the general population. A high proportion had defintely not seen their doctors in Austria, Italy and Yugoslavia. Among young people aged under 25 the percentage who had seen their doctor varied from 9 in Austria to 45 in Ireland and 46 in Hungary for males and from 10 in Italy to 52 in Ireland.

Although this pilot study of attempted suicides was a small study and not based on any strict sampling procedures, its results give rise to some questions which could be considered in future studies. The first of these arises from the comparatively large number of students, especially females, who made suicidal attempts. It may be asked what kind of support is provided for these young people, often under a number of stresses due to loneliness, high aspirations, absence from home, adapting to new educational techniques, and in many cases facing a foreign cultural situation. Is there any system by which older students, for example, are made positively responsible for certain individuals, and what is the role of the teaching staff in this respect?

A second point of importance is the question of what happens to the client when he leaves the service. Many in this study apparently did not get any kind of psychiatric after-care and for those who did it is not known what was done. Is individual care best, whether hospital or ambulatory, or is group therapy better, and to what extent can other community services be involved? The lack of visits by significant others in some centres and sex-age-groups raises the question of how the community itself is to be taught how to care for its members in difficulty. Suicide intervention services often do not accept calls from third parties, but it may be asked whether it is desirable to pursue a policy of noninterference if the outcome could be the death of a fellow citizen.

The training of general practitioners in suspecting and looking for possible suicidal attempts seems to be of considerable importance. Most particularly the psychodynamics and sociodynamics of suicide need to be studied, so that it can be recognized at the start of the process. Self-destruction may perhaps be reduced if medicine is not solely about diseases but also about people.

ANNEX IX

AGENDA

1. General introduction: concepts of suicide and parasuicide; simple definitions of terminology; elementary statistical data commonly available in countries
2. Modern trends in self-destructive behaviour
3. Psychopathology
4. Social and cultural aspects
5. Risk factors
6. Prevention, intervention and postvention in suicidal behaviour
7. Suicide prevention services and their evaluation
8. Information systems in suicide and attempted suicide
9. Research in suicide and attempted suicide
10. Training and education

ANNEX X

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